Library Edition

Information For

People With Medicare

And Those Who Serve Them

- Medicare & You 2001
- 2000 Guide to Health Insurance
- New health insurance now available for infants, children and teens
- Guide to Choosing a Nursing Home
- Medicare Savings for Qualified Individuals
- Medicare Preventive Services
- Medicare Worksheet for Comparing Health Plans
- www.medicare.gov
- Resources

Medicare & You

The knowledge to make good decisions

Resource Kit 2001

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HEALTH CARE FINANCING ADMINISTRATION

The Federal Medicare Agency

www.medicare.gov or 1-800-MEDICARE (1-800-633-4227)

The **Library Resource Kit** was designed specifically for librarians and provides useful information about the Medicare program (the federal health insurance program for the elderly and disabled). It contains tools that will assist you in serving your community and providing it with important health care information. The Health Care Financing Administration's Regional Offices are interested in on-going partnerships with you to educate your patrons about Medicare. A listing of the regional office staff, the states they serve, and projects ideas you could do together, is included in this Kit under Resources. Also included are promotional materials that your library may use. Should you have questions, you should call the regional office that covers your state.

For the most current information, the latest edition of publications, and most recent telephone numbers, please go to www.medicare.gov. If you have further questions, call the Medicare Choices helpline at 1-800-MEDICARE (1-800-633-4227).

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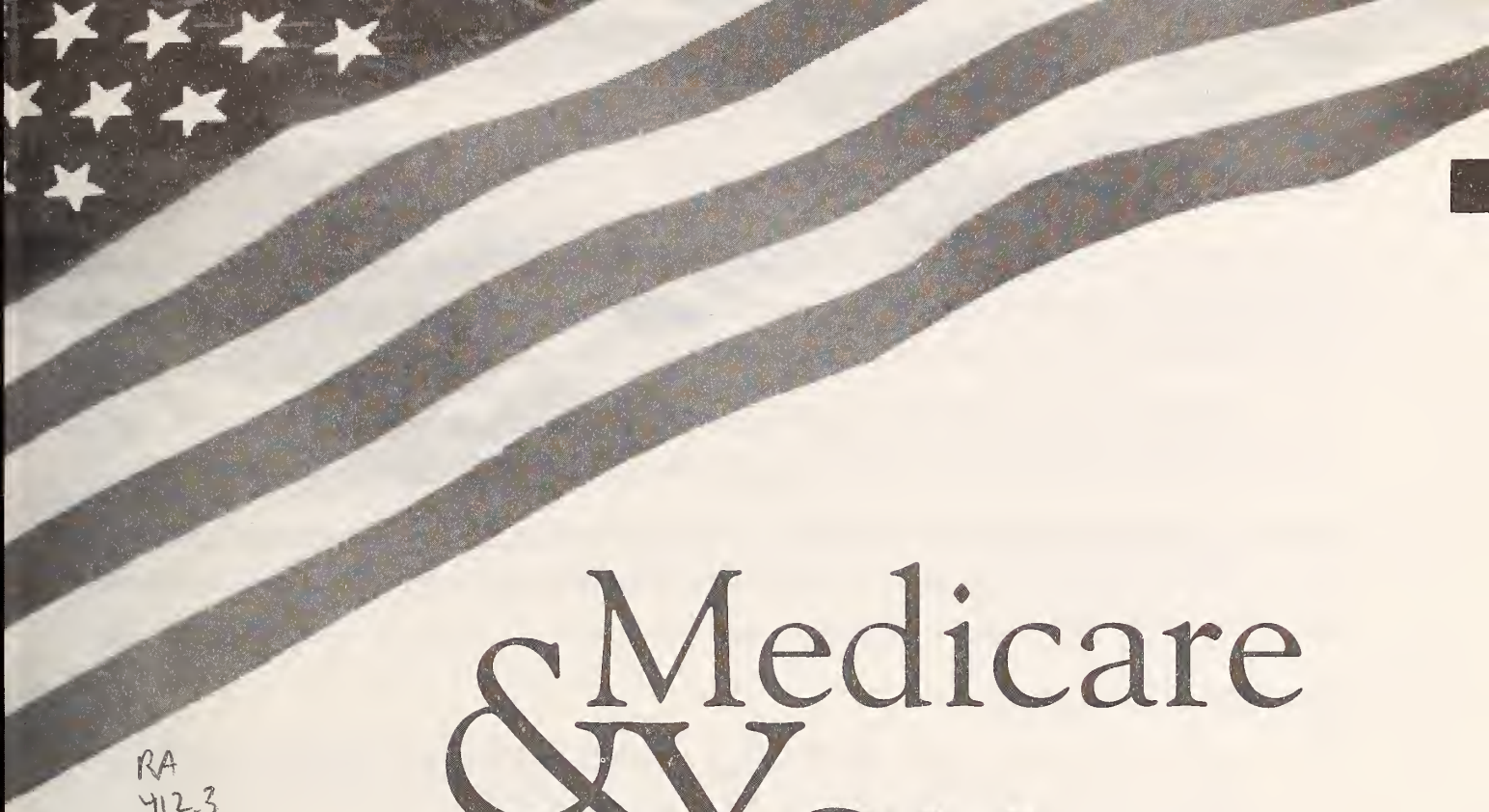

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Medicare & You 2001

This handbook has important information about:

- **Your Medicare benefits.**
- **Your Medicare plan choices.**
- **Medicare health plans in your area.**
- **Where to call for help.**

How do you find what you need? See page 3.

Please keep this handbook for future reference.

HEALTH CARE FINANCING ADMINISTRATION

The Federal Medicare Agency

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How to find what you need in this handbook:

Do you:	Look on page(s):
Want to look for a specific topic?	72 – 73. **Index**: See the Index for an alphabetical list of everything in this handbook and the page(s) where you will find the information you need.
Want to sign up for Medicare?	5 and 7
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A Quick Look At Medicare

Medicare is a health insurance program for:

- People age 65 or older.
- Some people with disabilities under age 65.
- People with **End-Stage Renal Disease** (permanent kidney failure requiring dialysis or a transplant).

Medicare Has Two Parts

Part A (Hospital Insurance, see page 5.)

Most people do not have to pay for Part A.

Part B (Medical Insurance, see page 7.)

Most people pay monthly for Part B.

You may have choices in how you get your health care.

- **The Original Medicare Plan -** For more information, see page 14.
- **Medicare Managed Care Plans (like HMOs) -** For more information, see page 16.
- ***NEW* Medicare Private Fee-for-Service Plans -** For more information, see page 17.

What is Medicare Part A?

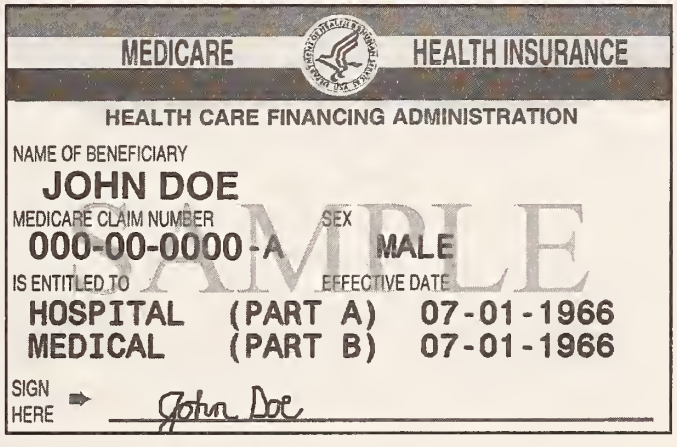
Part A (Hospital Insurance)

Helps Pay For: Care in hospitals as an inpatient, critical access hospitals*, skilled nursing facilities, hospice care, and some home health care. See page 6.

Cost: Most people get Part A automatically when they turn age 65. They do not have to pay a monthly payment called a **premium** for Part A because they or a spouse paid Medicare taxes while they were working.

If you (or your spouse) did not pay Medicare taxes while you worked and you are age 65 or older, you still may be able to buy Part A. If you are not sure if you have Part A, look on your red, white, and blue Medicare card (see sample card below). It will show "Hospital Part A" on the lower left corner of the card. You can also call the Social Security Administration toll-free at 1-800-772-1213 or call your local Social Security office for more information about buying Part A. If you get benefits from the Railroad Retirement Board, call your local RRB office or 1-800-808-0772.

Do you need a new Medicare card? Call the Social Security Administration toll-free at 1-800-772-1213 or call your local Social Security office.


MEDICARE HEALTH INSURANCE

HEALTH CARE FINANCING ADMINISTRATION

NAME OF BENEFICIARY
JOHN DOE

MEDICARE CLAIM NUMBER SEX
000-00-0000-A MALE

IS ENTITLED TO EFFECTIVE DATE
HOSPITAL (PART A) 07-01-1966
MEDICAL (PART B) 07-01-1966

SIGN HERE ➡ John Doe

SAMPLE

For More Information:

Call your Fiscal Intermediary about Part A bills and services (see pages 29A-31).

*Critical access hospitals (CAHs) are small facilities that give limited outpatient and inpatient services to people in rural areas. If you have questions about CAHs, call your HCFA Regional Office (see page 44), or your Fiscal Intermediary (see pages 29A-31).

Medicare Part A (Hospital Insurance) Helps Pay For:	What YOU Pay in 2000* in the Original Medicare Plan
Hospital Stays: Semiprivate room, meals, general nursing, and other hospital services and supplies (this includes care in critical access hospitals). This does not include private duty nursing, or a television or telephone in your room. It also does not include a private room, unless **medically necessary.** Inpatient mental health care coverage in an independent psychiatric facility is limited to 190 days in a lifetime.	**For each benefit period YOU pay:** • A total of $776 for a hospital stay of 1-60 days. • $194 per day for days 61-90 of a hospital stay. • $388 per day for days 91-150 of a hospital stay. (See **Reserve Days** on page 71.) • All costs for each day beyond 150 days.
Skilled Nursing Facility (SNF) Care: ** Semiprivate room, meals, skilled nursing and rehabilitative services, and other services and supplies (after a 3-day hospital stay). For more information on SNFs, see page 63. To get a booklet about SNF care, see page 66.	**For each benefit period YOU pay:** • Nothing for the first 20 days. • Up to $97 per day for days 21-100. • All costs beyond the 100th day in the benefit period. If you have questions about SNF care and conditions of coverage, call your Fiscal Intermediary (see pages 29A-31).
Home Health Care: ** Part-time skilled nursing care, physical therapy, occupational therapy, speech-language therapy, home health aide services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers) and supplies, and other services (see page 49). To get a booklet about home health care, see page 66.	**YOU pay:** • Nothing for home health care services. • 20% of the **Medicare-approved amount** for durable medical equipment. If you have questions about home health care and conditions of coverage, call your Regional Home Health Intermediary (see pages 32-33).
Hospice Care: ** Medical and support services from a Medicare-approved hospice, drugs for symptom control and pain relief, short-term respite care, care in a hospice facility, hospital, or nursing home when necessary, and other services not otherwise covered by Medicare. Home care is also covered. To get a booklet about hospice care, see page 66.	**YOU pay:** • A **copayment** of up to $5 for outpatient prescription drugs and 5% of the Medicare-approved payment amount for inpatient respite care (short-term care given to a hospice patient by another care giver, so that the usual care giver can rest). The amount you pay for respite care can change each year. If you have questions about hospice care and conditions of coverage, call your Regional Home Health Intermediary (see pages 32-33).
Blood: Pints of blood you get at a hospital or skilled nursing facility during a covered stay.	**YOU pay:** For the first 3 pints of blood, unless you or someone else donates blood to replace what you use.

* New Part A and B amounts will be available by January 1, 2001.
** You must meet certain conditions in order for Medicare to cover these services.

If you have general questions about Medicare Part A, call your Fiscal Intermediary (see pages 29A-31).

What is Medicare Part B?

Part B (Medical Insurance)

Helps Pay For: Doctors' services, outpatient hospital care, and some other medical services that Part A does not cover, such as the services of physical and occupational therapists, and some home health care. Part B helps pay for these covered services and supplies when they are **medically necessary** (see pages 8-10).

* The new Part B premium amount will be available by January 1, 2001. You may be able to get help from your state paying this premium (see page 11).

Cost: You pay the Medicare Part B **premium** of $45.50* per month. This is the 2000 amount and may change January 1, 2001. In some cases, this amount may be higher if you did not choose Part B when you first became eligible at age 65. **The cost of Part B may go up 10% for each 12-month period that you could have had Part B but did not sign up for it, except in special cases. You will have to pay this extra 10% for the rest of your life.** For more Part B enrollment information, see page 53.

Enrolling in Part B is your choice. You can sign up for Part B anytime during a 7-month period that begins 3 months before you turn 65. Visit your local Social Security office, or call the Social Security Administration at 1-800-772-1213 to sign up. If you choose to have Part B, the premium is usually taken out of your monthly Social Security, Railroad Retirement, or Civil Service Retirement payment. If you do not get any of these above payments, Medicare sends you a bill for your Part B premium every 3 months. You should get your Medicare premium bill by the 10th of the month. If you do not get your bill by the 10th, call the Social Security Administration at 1-800-772-1213 or your local Social Security office. If you get benefits from the Railroad Retirement Board, call your local RRB office or 1-800-808-0772.

For More Information:

Call your Medicare Carrier about Part B bills and services (see pages 25A-F).

Medicare Part B (Medical Insurance) Helps Pay For:	What YOU Pay in 2000* in the Original Medicare Plan (see Note below)
Medical and Other Services: Doctors' services (except for routine physical exams), outpatient medical and surgical services and supplies, diagnostic tests, ambulatory surgery center facility fees for approved procedures, and durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers). Also covers second surgical opinions. To get a booklet about second surgical opinions, see page 66.	**YOU pay:** • $100 **deductible** (pay once per calendar year). • 20% of **Medicare-approved amount** after the deductible, except in the outpatient setting. (See Q12 on page 56.)
Also covers outpatient physical and occupational therapy including speech-language therapy.	• 20% for all outpatient physical, occupational, and speech-language therapy services.
Outpatient mental health care.	• 50% for outpatient mental health care. (See Q25 on page 63.)
Clinical Laboratory Service: Blood tests, urinalysis, and more.	**YOU pay:** • Nothing for Medicare-approved services.
Home Health Care: ** Part-time skilled care, home health aide services, durable medical equipment when supplied by a home health agency while getting Medicare-covered home health care, and other supplies and services.	**YOU pay:** • Nothing for Medicare-approved services. • 20% of Medicare-approved amount for durable medical equipment.
Outpatient Hospital Services: Services for the diagnosis or treatment of an illness or injury. To get a booklet about payment for outpatient hospital services, see page 67.	**YOU pay:** • A coinsurance or fixed copayment amount which may vary according to the service.
Blood: Pints of blood you get as an outpatient, or as part of a Part B covered service.	**YOU pay:** For the first 3 pints of blood, then 20% of the Medicare-approved amount for additional pints of blood (after the deductible), unless you or someone else donates blood to replace what you use.

* New Part A and B amounts will be available by January 1, 2001.
** You must meet certain conditions in order for Medicare to cover these services or equipment.

Note: Actual amounts you must pay are higher if the doctor or supplier does not accept assignment, and you may have to pay the entire cost. Medicare will then send you its share of the costs (see Q12 on page 56). If you have general questions about Medicare Part B, call your Medicare Carrier (see pages 25A-F). If you have questions about durable medical equipment, including diabetic supplies, call your DMERC (see page 28).

Medicare Part B Covered Preventive Services	Who is covered...	What YOU pay in the Original Medicare Plan...
Bone Mass Measurements: Varies with your health status.	Certain people with Medicare who are at risk for losing bone mass.	20% of the Medicare-approved amount (or a set copayment amount) after the yearly Part B **deductible**.
Colorectal Cancer Screening: • Fecal Occult Blood Test - Once every 12 months. • Flexible Sigmoidoscopy* - Once every 48 months. • Colonoscopy* - Once every 24 months if you are at high risk for cancer of the colon. • Barium Enema - Doctor can substitute for sigmoidoscopy or colonoscopy.	All people with Medicare age 50 and older. However, there is no age limit for having a colonoscopy.	Nothing for the fecal occult blood test. For all other tests, 20% of the Medicare-approved amount after the yearly Part B deductible. (*25% if performed in an ambulatory surgical center or hospital outpatient department.)
Diabetes Services: • Coverage for glucose monitors, test strips, and lancets.	All people with Medicare who have diabetes (insulin users and non-users).	20% of the Medicare-approved amount after the yearly Part B deductible.
• Diabetes self-management training.	If requested by your doctor or other provider.	20% of the Medicare-approved amount after the yearly Part B deductible.
Mammogram Screening: Once every 12 months. (You can also get one baseline mammogram between ages 35 and 39.)	All women with Medicare age 40 and older.	20% of the Medicare-approved amount with no Part B deductible.
Pap Smear and Pelvic Examination: (Includes a clinical breast exam) Once every 36 months. Once every 12 months if you are high risk for cervical or vaginal cancer, or if you are of childbearing age and have had an abnormal Pap smear in the preceding 36 months.	All women with Medicare.	Nothing for the Pap smear lab test. For Pap smear collection and pelvic and breast exams, 20% of the Medicare-approved amount (or a set copayment amount) with no Part B deductible.
Prostate Cancer Screening: • Digital Rectal Examination - Once every 12 months. • Prostate Specific Antigen (PSA) Test - Once every 12 months.	All men with Medicare age 50 and older.	Generally, 20% of the Medicare-approved amount for the digital rectal exam after the yearly Part B deductible. No **coinsurance** and no Part B deductible for the PSA Test.
Shots (vaccinations): • Flu Shot - Once a year in the fall or winter. • Pneumonia Shot - One shot may be all you ever need. Ask your doctor. • Hepatitis B Shot - If you are at medium to high risk for hepatitis.	All people with Medicare.	Nothing for flu and pneumonia shots if the health care provider accepts assignment (see page 56). For Hepatitis B shots, 20% of the Medicare-approved amount (or set copayment amount) after the yearly Part B deductible.

Part B also helps pay for:

- Ambulance services (when other transportation would endanger your health).
- Artificial limbs and eyes.
- Braces - arm, leg, back, and neck.
- Chiropractic services (limited).
- Emergency care.
- Eyeglasses - one pair after cataract surgery with an intraocular lens.
- Immunosuppressive drug therapy (limited), extended coverage available for transplant patients including some ESRD patients.
- Kidney dialysis and kidney transplants.
- Medical supplies - items such as ostomy bags, surgical dressings, splints, casts, and some diabetic supplies.
- Outpatient prescription drugs (very limited). For example, some oral cancer drugs.
- Preventive services (see page 9).
- Prosthetic devices, including breast prosthesis after mastectomy.
- Services of practitioners such as clinical psychologists, social workers, and nurse practitioners.
- Transplants - heart, lung, kidney, pancreas, and liver (under certain conditions).
- X-rays and some other diagnostic tests.

What is not paid for by Medicare Part A and Part B in the Original Medicare Plan?

The Original Medicare Plan does not cover everything. Your out-of-pocket costs for health care will include but are not limited to:

- Acupuncture.
- **Deductibles**, **coinsurance**, or **copayments** when you get health care services (see the "What YOU Pay" part of the charts on pages 6, 8, and 9).
- Dental care and dentures (in most cases).
- Cosmetic surgery.
- Custodial care (help with bathing, dressing, toileting, and eating) at home or in a nursing home.
- Health care you get while traveling outside of the United States (except in limited cases).
- Hearing aids.
- Orthopedic shoes.
- Outpatient prescription drugs (with only a few exceptions).
- Routine foot care.
- Routine eye care.
- Routine or yearly physical exams.
- Screening tests except those listed on page 9.
- Shots (vaccinations) except those listed on page 9.
- Your monthly Part B **premium** ($45.50 in 2000*).

* New Part A and B amounts will be available by January 1, 2001.

You may be able to get help with the costs Medicare does not cover (see page 11). You may be able to join a Medicare managed care plan or a Private Fee-for-Service plan and get extra benefits (see pages 16-22).

Getting help to pay your health care costs

Most of your health care costs are covered if you have Medicare and you qualify for Medicaid. **Medicaid** is a joint federal and state program that helps pay medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state. People on Medicaid may also get coverage for nursing home care and outpatient prescription drugs which are not covered by Medicare.

States also have programs that pay some or all of Medicare's premiums and may also pay Medicare deductibles and coinsurance for certain people who have Medicare and a low income.

To qualify, you must have:

- Part A (Hospital Insurance, see page 5 for more information about Part A),
- Assets, such as bank accounts, stocks, and bonds that are not more than $4,000 for a single person, or $6,000 for a couple, and
- A monthly income that is below certain limits (see chart below).

Programs That Help Pay Medical Expenses*

Monthly Income Limits for 2000**	Program Will Pay	Program Name
$716 Individual or $958 Couple	Premiums, deductibles, and coinsurance	Qualified Medicare Beneficiary (QMB)
$855 Individual or $1,145 Couple	Medicare Part B premiums	Specified Low-Income Medicare Beneficiary (SLMB)
$960 Individual or $1,286 Couple	Medicare Part B premiums	Qualifying Individual (QI-1)
$1,238 Individual or $1,661 Couple	A small part of your Medicare Part B premiums	Qualifying Individual (QI-2)

*These programs may not be available in Guam, Puerto Rico, the Virgin Islands, the Northern Mariana Islands, and American Samoa.

**Slightly higher income amounts are allowed in Alaska and Hawaii. Income limits will go up slightly in 2001, and new limits will be available by April 1, 2001.

For more information about these programs, call your state medical assistance office (see pages 42-43). If you need more help, please call 1-800-MEDICARE (1-800-633-4227). The customer service representative will help you find the phone number in your State.

For information about supplement insurance (Medigap), see page 15.

Insure Kids Now

Free or low-cost health insurance is available now in your State for uninsured children under age 19. Call toll-free 1-877-KIDS-NOW (1-877-543-7669) for more details.

Other Kinds of Health Insurance You Might Have

Do you know what health care insurance you have and what it helps pay for? Fall is a good time to review your coverage. Medicare may not be the only health care coverage you can get. You might be able to get more health care coverage, help to lower your out-of-pocket costs, or more benefits than Medicare alone has. Check with your current or past employer or union, or the military if you are a veteran or military retiree. You might be able to get insurance through them. This kind of insurance can help pay the costs Medicare does not pay.

Whether you qualify for employer, union, military, or other health care coverage, you should learn about all of the different kinds of health care coverage. What you choose will affect how much you pay, what benefits you may have, which doctors you can see, and other things that may be important to you.

If you or your spouse still work or are retired, you may be able to get employer or union health care coverage:

- Call the employer or union to find out if you can get health care coverage based on your or your spouse's past or present employment.
- If you can get this coverage, ask your benefits administrator to help you compare their costs and benefits to Medicare's. In addition, there are rules about who pays first (see page 67 to get a booklet about who pays first).

Caution: If you already have employer or union coverage, talk to your employer or union before you make any changes. If you drop this coverage, you may not be able to get it back.

If you are a veteran or a military retiree, you may be able to get health care benefits:

- If you are a veteran, call the U.S. Department of Veteran Affairs at 1-800-827-1000. If you or your spouse are retired from the military, call the Department of Defense at 1-800-538-9552 for more information.

If you have a low income and limited assets, you may qualify for help paying your health care costs:

- See page 11 to see if you qualify for help from your state to pay your health care costs. You may also call your state medical assistance office (see pages 42-43).

Note: For information about Medicare Supplement Insurance (Medigap), see page 15.

Medicare health plan choices in 2001

In Medicare, you may be able to get your health care coverage from:

- **The Original Medicare Plan (see pages 14-15).**

Or, you can get your coverage through another Medicare health plan under Medicare + Choice. Congress created the Medicare + Choice program to let more private insurance companies offer coverage to people in Medicare. Some of your choices may include:

- **A Medicare managed care plan, like an HMO (see pages 16-22), or**
- **A Medicare Private Fee-for-Service plan (see pages 17-22).**

These are the only types of Medicare health plans currently available.

No matter how you get your Medicare benefits, you are still in the Medicare program.

In every Medicare health plan:

- You pay the monthly Medicare Part B premium of $45.50 in 2000. It is usually taken out of your monthly Social Security, Railroad Retirement, or Civil Service Retirement payment.
- You get all the Medicare Part A and Part B covered services.

When choosing a Medicare health plan, think about:

Cost	What will my out-of-pocket costs be?
Doctor Choice	Can I see the doctor(s) I want to see?
Benefits	Do I need extra benefits and services, like prescription drugs, eye exams, hearing aids, or routine physical exams?
Convenience	Where are the doctors' offices and what are their hours?
Quality	How well does the plan keep its members healthy or treat them when they are sick? Call 1-800-MEDICARE (1-800-633-4227) or look at www.medicare.gov on the Internet for information on Medicare health plan quality. **Quality** information is not available yet for Medicare Private Fee-for-Service plans because they are new.

The Original Medicare Plan

The Original Medicare Plan is also known as "fee-for-service." This plan, offered by the federal government, is available nationwide. You are usually charged a fee for each health care service or supply you get. If you are happy getting your health care this way, you do not have to change. You will stay in the Original Medicare Plan unless you choose to join a **Medicare managed care plan** or a **Private Fee-for-Service plan**.

If you are in the Original Medicare Plan, you use your red, white, and blue Medicare card when you get health care (see the sample card on page 5).

How does the Original Medicare Plan work?

- You may go to any doctor, specialist, or hospital that accepts Medicare. Generally, a fee is charged each time you get a service.
- You pay the monthly Part B premium of $45.50 in 2000.
- You pay an amount for your health care each year (**deductible**) before Medicare pays its part. Then, Medicare pays its share, and you pay your share (**coinsurance**). After you get a health care service, you get an Explanation of Medicare Benefits or a Medicare Summary Notice in the mail. These are sent by a company that handles bills for Medicare. The notice lists the amount you may be billed.

Your costs in the Original Medicare Plan

What you pay out-of-pocket depends on:

- Whether your doctor or supplier agrees to accept assignment (see Q12 on page 56).
- How often you need health care.
- What type of health care you need.
- Whether you get health care while traveling outside of the United States, since in most cases, you would pay for this care.
- Whether you get services or supplies not covered by Medicare.

Your costs in the Original Medicare Plan (continued)

To help cover the costs the Original Medicare Plan does not cover, you can:

- Keep or get employer or union health coverage (see page 12), or
- Buy a **Medigap** Policy (Medicare Supplement Insurance)* (see below), or
- Check if you qualify for help from your State (see page 11).

* For the rest of this book, Medicare Supplement Insurance policies will be called Medigap policies.

You may be able to save money by joining one of the other Medicare health plans (see pages 16-22).

For more information on the Original Medicare Plan, see Q11 and Q12 on page 56.

Filling the gaps in Original Medicare Plan coverage

What is a Medigap policy?

A "Medigap" policy fills gaps in Original Medicare Plan coverage. Medigap insurance must follow federal and state laws. These laws protect you. All Medigap policies are clearly marked "Medicare Supplement Insurance."

In all states, except Massachusetts, Minnesota, and Wisconsin, a Medigap policy must be one of ten standardized policies to help you compare them easily. Each policy has a different set of benefits. Two of the standardized policies may have a high deductible option. In addition, any standardized policy may be sold as a "Medicare SELECT" policy. Medicare SELECT policies usually cost less because you must use certain hospitals and doctors. In an emergency, you may use any doctor or hospital.

For more information about Medigap policies:

- Read Q13-Q16 on pages 57-60.
- Call 1-800-MEDICARE (1-800-633-4227) and ask for a free copy of the *2000 Guide to Health Insurance for People with Medicare*. You can also look on the Internet at www.medicare.gov to read or print this booklet.

Medicare managed care plans and Private Fee-for-Service Plans

Medicare managed care plans and Private Fee-for-Service plans are not available in all areas. If you are in either of these types of plans, you must continue to pay the monthly Medicare Part B premium of $45.50 in 2000. You may also have to pay any additional monthly premium.

What is a Medicare managed care plan?

A Medicare managed care plan, sometimes called an HMO, is a health plan offered by private insurance companies. Many people with Medicare choose a managed care plan.

How does managed care work?

- Medicare pays a set amount of money every month to the private insurance company.
- You can often get extra benefits, like prescription drugs.
- In most managed care plans, you can only go to certain doctors and hospitals that agree to treat members of the plan. Call the plan you are interested in to see which doctors are in the plan.
- Doctors can join or leave managed care plans at any time. If your doctor leaves your plan, ask your plan for the names of plan doctors in your area. If you want to keep getting care from your doctor, ask if he or she belongs to another Medicare managed care plan. You may want to join that plan.
- Generally, you can only see a specialist (like a cardiologist) when you get a **referral**, which means your **primary care doctor** says it is OK to go.
- Some managed care plans offer a Point-of-Service option. This allows you to go to other doctors and hospitals who are not a part of the plan. Most of the time this option costs you more, and gives you more choices.

What is a Private Fee-for-Service plan?

This is a new type of health care plan in some areas of the country. A Private Fee-for-Service plan is a Medicare health plan offered by a private insurance company. It is not the same as the Original Medicare Plan, which is offered by the federal government.

How does a Private Fee-for-Service plan work?

- Medicare pays a set amount of money every month to the private insurance company.
- The private insurance company provides health care coverage to people with Medicare who join this plan. You pay and the insurance company pays a fee for each doctor visit or service you get.
- The insurance company, rather than the Medicare program, decides how much it pays, and how much you pay, for the services you get.
- You can go to any doctor or hospital that accepts the plan's payment.
- You may be able to get extra benefits, like coverage for additional days in the hospital.

Caution: Ask the plan if it has any "pre-notification" requirements (for example, a requirement that you notify the plan of any planned inpatient admissions).

Who can join a Medicare managed care plan or Private Fee-for-Service plan?

If you have Medicare, you can join either of these types of plans if:

- You have both Part A (Hospital Insurance) and Part B (Medical Insurance).
- You live in the service area of the plan. The service area is where the plan accepts members. In the case of a managed care plan, it's also where you get services from the plan.
- You do not have **End-Stage Renal Disease** (permanent kidney failure requiring dialysis or a kidney transplant). ESRD patients can stay in the plan they are in or join another plan offered by the same company. If you've had a successful kidney transplant, you may be able to join a plan. Call 1-800-MEDICARE (1-800-633-4227) for more information about End-Stage Renal Disease and Medicare health plans.

Note: If you are already in a Medicare managed care plan and have only Part B, you may stay in your plan.

If you join one of these plans:

- You are still in the Medicare program.
- You must continue to pay the monthly Medicare Part B premium of $45.50 in 2000.
- You still get all your regular Medicare-covered services (see pages 6, 8, and 9).
- You have Medicare rights and protections (see pages 45-51).

Your costs in a Medicare managed care plan or Private Fee-for-Service plan

What you pay out-of-pocket depends on:

- Whether the plan charges a monthly **premium** in addition to your monthly Part B premium of $45.50 in 2000.

  Note: If you don't pay the additional premium charged by your plan, you may be returned to the Original Medicare Plan.

- How much the plan decides you must pay for each visit.
- The type of health care you need and how often you get it.
- How much the plan charges for extra benefits.

Also:

- In a Medicare managed care plan, you may pay more if you get health care outside the service area of the plan. See exceptions for emergency and urgently needed care on page 62 (Q23 and Q24).
- In a Private Fee-for-Service plan, you may pay more if the plan lets doctors, hospitals, and other providers bill you more than the plan pays for services. If this is allowed, there may be a limit to what they can charge, and you must pay the difference.

How can I tell if I am in a Medicare managed care plan or Private Fee-for-Service plan?

If you joined a Medicare managed care plan or Private Fee-for-Service plan, you should have a membership card with the name of the plan on it. If you are not sure if you are in one of these plans, you can call the number listed on your membership card, or call the Social Security Administration at 1-800-772-1213, or call your local Social Security Office to find out. If you get benefits from the Railroad Retirement Board, call your local RRB office or 1-800-808-0772.

When can I join one of these plans?

During the month of November, Medicare health plans must accept new members. In most cases, if you join a Medicare health plan in November 2000, your coverage begins on January 1, 2001.

Most Medicare health plans may also accept new members at other times of the year. Some Medicare health plans limit the number of members in their plans. These plans may not accept new members all of the time. A plan can tell you if it is signing up new members.

How do I join a Medicare managed care plan or Private Fee-for-Service plan?

To join a plan:

1. Call the plan and ask for an enrollment form. Fill out the form and mail it to the plan, or
2. Get an enrollment form from a plan representative. Fill out the form and give it to the plan representative.

You will get a letter from the plan telling you when your coverage begins.

Can I join more than one plan?

No. You can't join more than one Medicare health plan at the same time. If you try to join more than one Medicare health plan with the same starting dates, you may end up enrolled in the plan you did not want to be in.

What if I move out of the plan's service area?

You will need to call the health plan to see if you can stay in the plan if you move out of the plan's service area. If you must leave the plan, you must disenroll. You will be covered under the Original Medicare Plan. Or, you can choose to join another Medicare health plan, if one is available in your area.

What if I want to leave the plan?

In the year 2001, you may leave a plan at any time for any reason. Write to the plan or to the Social Security Administration. Tell them you want to leave the plan. The plan should send you a letter with the date your plan coverage ends. If you don't get a letter, call the plan and ask for the date. When you leave a plan, you are automatically returned to the Original Medicare Plan, unless you join another Medicare managed care plan or Private Fee-for-Service plan. If you join another one of these plans, you should get a letter telling you when your coverage starts.

Starting in 2002, you may be able to leave a plan only at certain times. Call 1-800-MEDICARE (1-800-633-4227) for more information.

If you join a new Medicare managed care plan or Private Fee-for-Service plan and change your mind, you must write to the new plan. Tell them you want to cancel.

If you change your mind and your new plan has:

- not processed your enrollment, you can stay in your old plan (including the Original Medicare Plan), or you can join a new Medicare health plan.
- already processed your enrollment, you will be disenrolled from your old plan and enrolled in the new plan. If you want to return to your old plan, you have to re-enroll in it. If your old plan was the Original Medicare Plan, you will be returned to it when you disenroll from the new plan.

Can I keep my Medigap policy if I join one of these plans?

Yes, you can keep it. However, it may cost you a lot and you may get little benefit from it while you are in a Medicare managed care plan or Private Fee-for-Service plan. If you drop your Medigap policy, you may not be able to get it back unless you are in a situation listed in Q15 on pages 58-59.

Who decides where Medicare managed care plans and Private Fee-for-Service plans will be available?

Medicare managed care plans and Private Fee-for-Service plans are offered by private companies.

A company can decide that a plan will be available to everyone with Medicare in a state, or be open only in certain counties. The company may also choose to offer more than one plan in an area, with different benefits and costs. Each year, the companies offering Medicare managed care plans and Private Fee-for-Service plans can decide to join or leave Medicare.

How long are Medicare managed care plans and Private Fee-for-Service plans required to stay in Medicare? When can they leave Medicare?

When Medicare health plans sign a contract with Medicare, they agree to stay in Medicare for at least one year (January 1 through December 31). Private companies offer managed care plans and Private Fee-for-Service plans. Each year, they make a business decision to stay in or leave the Medicare program. Costs and extra benefits can also change.

Your plan must let you know if they intend to leave Medicare at the end of the year. You will be notified before your plan coverage ends. The notice the plan must send you will tell you if other Medicare health plans are offered in your area, and what protections you have.

If the plan's quality is poor or they commit fraud, a plan can be asked to leave the Medicare program at any time during the year. You will get a notice before this happens. The notice will tell you how to find a new plan, and what protections you have.

What if I have employer or union coverage?

If you join a Medicare managed care plan or Private Fee-for-Service plan and also have employer or union coverage, you may, in some cases, still be able to use this coverage along with your Medicare health plan coverage. Talk to your benefits administrator about the rules that apply.

Medicare Medical Savings Account Plans

You may have heard about **Medicare Medical Savings Accounts**. At the time this handbook was printed, no private insurance companies were offering these types of plans to people with Medicare. To find out if any of these plans have become available in your area, or to learn more about them, call 1-800-MEDICARE (1-800-633-4227) and ask for a free copy of *Your Guide to Medicare Medical Savings Accounts*.

For more information about your Medicare health plan choices:

1. See Q17-Q24 on pages 60-62.
2. Call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) and ask for:
   - A free copy of detailed plan information on costs, extra benefits, **quality**, and disenrollment information for plans in your area.
   - A free copy of *The Worksheet for Comparing Medicare Health Plans* to help you compare plans.
   - A free copy of *Your Guide to Private Fee-for-Service Plans*.
3. Look on the Internet at www.medicare.gov to find plan information for your area, including their costs, extra benefits, quality, and disenrollment information, and booklets that you can read or print out.

Moving?
Call 1-800-MEDICARE (1-800-633-4227), or look on the Internet at www.medicare.gov. Click on Medicare Health Plan Compare to get more information on plans in your new area. Remember to call the Social Security Administration at 1-800-772-1213 to change your address.

Where to call for help with your Medicare questions

The next 29 pages have phone numbers you may call for help. If there is a special number for your state, it will be listed.

If you have questions about...	Call...
Changing your address, Medicare Part A or Part B, lost Medicare card, and Social Security benefits (see page 24).	Social Security Administration (SSA)
Medigap policies, long-term care insurance, Medicare health plan choices, Medicare rights and protections, and help with filing an appeal (see pages 26-27).	State Health Insurance Assistance Program
Part B bills, services, and fraud and abuse (see pages 25 A-F).	Medicare Carrier
Part A bills and services, hospital care, skilled nursing care, and fraud and abuse (see pages 29A-31).	Fiscal Intermediary (FI)
General Medicare information, ordering Medicare booklets, and information about health plans (see page 24).	1-800-MEDICARE Helpline
Discrimination (see page 44).	Office for Civil Rights
Reporting fraud and abuse (see page 24).	Office of the Inspector General
Complaints about quality of care, and filing an appeal or complaint (see pages 34-39).	Peer Review Organization (PRO)
Medigap policies available in your area, and insurance questions (see pages 40-41).	State Insurance Department
Low-income programs to help pay medical bills (see pages 42-43).	State Medical Assistance Office
Medicare bills and coverage, RRB benefits, lost Medicare card, Medicare premium amounts, and enrolling in Medicare (see page 24).	Railroad Retirement Board (RRB) (Railroad Retirement beneficiaries only)

If you are enrolled in a Medicare managed care plan or Private Fee-for-Service plan, you should call your plan with questions about bills, health services, and appeals.

Note: At the time of printing, telephone numbers listed were correct. Phone numbers sometimes change. To get the most up-to-date phone numbers, call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) or go to the Internet at www.medicare.gov and click on Helpful Contacts.

The telephone numbers on this page are the same for all states.

1-800-MEDICARE Helpline

Call about:

- Information about health plans
- Ordering Medicare booklets
- General Medicare information
- TTY/TDD and local phone numbers
- Information about health information fairs in your area

All States — 1-800-MEDICARE
1-800-633-4227
TTY/TDD: 1-877-486-2048

Coordination of Benefits Contractor

Call about:

- Medicare Secondary Payer
- Questions about who pays first

All States — 1-800-999-1118

Department of Health and Human Services
Office of the Inspector General

Call about:

- Reporting fraud and abuse in any federal health care program

All States — 1-800-447-8477
TTY/TDD: 1-800-377-4950

Railroad Retirement Board

Call about:

- Signing up for Medicare Part A and Part B, lost RRB Medicare card, address change
- Part B bills and services (Palmetto GBA 1-800-833-4455)
- Part A bills and services (see Fiscal Intermediary on pages 29A-31)

(RRB Beneficiaries Only)
All States — 1-800-808-0772

Social Security Administration

Call about:

- Changing your address
- Lost Medicare card
- Signing up for Medicare Part A and Part B
- Medicare premium problems

All States — 1-800-772-1213
TTY/TDD: 1-800-325-0778

Veterans Administration

Call about:

- Medical benefits

All States — 1-800-827-1000

Medicare Carrier: Call about questions on Medicare Part B coverage, bills and medical services, or for information on how to recognize Medicare fraud and abuse. If you get benefits from the Railroad Retirement Board, see page 24.

Alabama
Blue Cross Blue Shield of Alabama,
1(800)292-8855
TTY/TDD: 1(800)548-2547

Arizona
Noridian Mutual Insurance Company,
1(800)444-4606
TTY/TDD: 1(303)858-5903

Colorado
Noridian Mutual Insurance Company,
1(800)332-6681
TTY/TDD: 1(303)858-5903

Alaska
Noridian Mutual Insurance Company,
1(800)444-4606
TTY/TDD: 1(303)858-5903

Arkansas
Blue Cross Blue Shield of Arkansas,
1(800)482-5525 in-state calls only
TTY/TDD: 1(501)378-3009

Connecticut
Florida Blue Cross Blue Shield,
1(800)982-6819 in-state calls only
TTY/TDD: 1(203)639-3059

American Samoa
Noridian Mutual Insurance Company,
1(800)444-4606
TTY/TDD: 1(303)858-5903

California
National Heritage Insurance Company,
1(800)952-8627 in-state calls only
TTY/TDD: 1(530)634-7538

Delaware
Trailblazer Health Enterprises,
1(800)444-4606
TTY/TDD: 1(877)486-2048

Medicare Carrier: Call about questions on Medicare Part B coverage, bills and medical services, or for information on how to recognize Medicare fraud and abuse.

Florida
Blue Cross Blue Shield,
1(800)333-7586 in-state calls only
TTY/TDD: 1(800)754-7820

Georgia
Cahaba Government Benefit Administration,
1(800)727-0827
TTY/TDD: 1(800)377-4950

Guam
Noridian Mutual Insurance Company,
1(800)444-4606
TTY/TDD: 1(303)858-5903

Hawaii
Noridian Mutual Insurance Company,
1(800)444-4606
TTY/TDD: 1(303)858-5903

Idaho
Cigna Medicare,
1(800)627-2782 in-state calls only
TTY/TDD: 1(800)627-2782

Illinois
Wisconsin Physicians Service,
1(800)642-6930
TTY/TDD: 1(800)535-6152

Indiana
Adminastar Federal,
1(800)622-4792
TTY/TDD: 1(877)486-2048

Iowa
Noridian Mutual Insurance Company,
1(800)532-1285
TTY/TDD: 1(800)735-2943

Kansas
Blue Cross Blue Shield of Kansas,
1(800)432-3531 in-state calls only
TTY/TDD: 1(800)430-8757

Kentucky
Adminastar Federal,
1(800)999-7608
TTY/TDD: 1(317)841-4677

Louisiana
Louisiana Medicare - Part B,
1(800)462-9666 in-state calls only
TTY/TDD: 1(225)231-2292

Maine
National Heritage Insurance Company,
1(800)882-1228
TTY/TDD: 1(800)559-0443

Medicare Carrier: Call about questions on Medicare Part B coverage, bills and medical services, or for information on how to recognize Medicare fraud and abuse.

Maryland
Trailblazer Health Enterprises,
1(800)444-4606
TTY/TDD: 1(877)486-2048

Minnesota
Wisconsin Physician Services,
1(800)352-2762 in-state calls only
TTY/TDD: 1(800)627-3529

Montana
Blue Cross Blue Shield of Montana,
1(800)332-6146 in-state calls only
TTY/TDD: 1(800)238-5086

Massachusetts
National Heritage Insurance Company,
1(800)882-1228
TTY/TDD: 1(800)559-0443

Mississippi
Cahaba Health Benefits Administration,
1(800)682-5417 in-state calls only
TTY/TDD: 1(601)977-5820

Nebraska
Blue Cross Blue Shield,
1(800)633-1113
TTY/TDD: 1(800)430-8757

Michigan
Wisconsin Physicians Service,
1(800)482-4045
TTY/TDD: 1(800)535-6152

Missouri
Blue Cross Blue Shield of Arkansas,
1(800)392-3070 in-state calls only
TTY/TDD: 1(877)645-9577
Eastern Missouri

Blue Cross Blue Shield,
1(800)892-5900
TTY/TDD: 1(800)430-8757
Kansas City Area

Nevada
Noridian Mutual Insurance Company,
1(800)444-4606
TTY/TDD: 1(303)858-5903

Medicare Carrier: Call about questions on Medicare Part B coverage, bills and medical services, or for information on how to recognize Medicare fraud and abuse.

New Hampshire
National Heritage Insurance Company,
1(800)882-1228
TTY/TDD: 1(800)559-0443

New York
Blue Cross Blue Shield,
1(800)252-6550
TTY/TDD: 1(877)486-2048
Services Upstate NY

Empire Medicare Services,
1(800)442-8430
TTY/TDD: 1(516)244-5101

Group Health, Inc.,
1(800)632-5572
TTY/TDD: 1(212)721-1782
Queens County only

Northern Mariana Islands
Noridian Mutual Insurance Company,
1(800)444-4606
TTY/TDD: 1(303)858-5903

New Jersey
Empire Medicare Services - New Jersey Operations,
1(800)462-9306
TTY/TDD: 1(800)992-0165

North Carolina
Cigna Medicare,
1(800)672-3071 in-state calls only
TTY/TDD: 1(800)686-5517

Ohio
Nationwide Mutual Insurance Company,
1(800)282-0530
TTY/TDD: 1(800)542-5250

New Mexico
Blue Cross Blue Shield of Arkansas,
1(800)423-2925
TTY/TDD: 1(800)822-9472

North Dakota
Noridian Mutual Insurance Company,
1(800)247-2267
TTY/TDD: 1(303)858-5903

Oklahoma
Blue Cross Blue Shield of Arkansas,
1(800)522-9079
TTY/TDD: 1(800)822-9472

Medicare Carrier: Call about questions on Medicare Part B coverage, bills and medical services, or for information on how to recognize Medicare fraud and abuse.

Oregon
Noridian Mutual Insurance Company,
1(800)444-4606
TTY/TDD: 1(303)858-5903

Pennsylvania
HGS Administrators,
1(800)746-5680
TTY/TDD: 1(800)242-8471

Puerto Rico
Triple S, Inc.,
1(800)981-7015 in-state calls only
TTY/TDD: 1(787)782-5430

Rhode Island
Blue Cross Blue Shield of Rhode Island,
1(800)662-5170
TTY/TDD: 1(888)239-3356

South Carolina
Palmetto Government Benefits Administrator,
1(800)868-2522
TTY/TDD: 1(800)223-1296

South Dakota
Noridian Mutual Insurance Company,
1(800)437-4762
TTY/TDD: 1(303)858-5903

Tennessee
Cigna Medicare,
1(800)342-8900 in-state calls only
TTY/TDD: 1(800)686-5485

Texas
Trailblazer Health Enterprises,
1(800)442-2620
TTY/TDD: 1(800)516-6684

Utah
Blue Cross Blue Shield,
1(800)426-3477
TTY/TDD: 1(800)346-4128

Vermont
National Heritage Insurance Company,
1(800)882-1228
TTY/TDD: 1(800)559-0443

Virgin Islands
Triple S, Inc.,
1(800)474-7448 in-state calls only

Medicare Carrier: Call about questions on Medicare Part B coverage, bills and medical services, or for information on how to recognize Medicare fraud and abuse.

Virginia
Trailblazer Health Enterprises,
1(800)444-4606

West Virginia
Nationwide Mutual Insurance Company,
1(800)848-0106
TTY/TDD: 1(800)542-5250

Washington
Noridian Mutual Insurance Company,
1(800)444-4606
TTY/TDD: 1(303)858-5903

Wisconsin
Wisconsin Physicians Service,
1(800)944-0051 in-state calls only
TTY/TDD: 1(800)828-2837

Washington, D.C.
Trailblazer Health Enterprises,
1(800)444-4606
TTY/TDD: 1(877)486-2048

Wyoming
Noridian Mutual Insurance Company,
1(800)442-2371
TTY/TDD: 1(303)858-5903

State Health Insurance Assistance Program: Call for help with buying a Medigap policy or long-term care insurance, dealing with payment denials or appeals, Medicare rights and protections, help with complaints about your care or treatment, help choosing a Medicare health plan, or Medicare bills.

Alabama 1(800)243-5463 in-state calls only	**Illinois** 1(800)548-9034 in-state calls only
Alaska 1(800)478-6065 in-state calls only	**Indiana** 1(800)452-4800
American Samoa 1(808)586-7299	**Iowa** 1(800)351-4664
Arizona 1(800)432-4040	**Kansas** 1(800)860-5260 in-state calls only
Arkansas 1(800)224-6330	**Kentucky** 1(877)293-7447 in-state calls only
California 1(800)434-0222	**Louisiana** 1(800)259-5301 in-state calls only
Colorado 1(888)696-7213	**Maine** 1(800)750-5353 in-state calls only
Connecticut 1(800)994-9422 in-state calls only	**Maryland** 1(800)243-3425 in-state calls only
Delaware 1(800)336-9500 in-state calls only	**Massachusetts** 1(800)882-2003 in-state calls only
Florida 1(800)963-5337 in-state calls only	**Michigan** 1(800)803-7174
Georgia 1(800)669-8387	**Minnesota** 1(800)333-2433
Guam 1(808)586-7299	**Mississippi** 1(800)948-3090
Hawaii 1(808)586-7299	**Missouri** 1(800)390-3330
Idaho 1(800)247-4422 in-state calls only	**Montana** 1(800)332-2272 in-state calls only

State Health Insurance Assistance Program: Call for help with buying a Medigap policy or long-term care insurance, dealing with payment denials or appeals, Medicare rights and protections, help with complaints about your care or treatment, help choosing a Medicare health plan, or Medicare bills.

Nebraska 1(800)234-7119	**Rhode Island** 1(800)322-2880 in-state calls only
Nevada 1(800)307-4444	**South Carolina** 1(800)868-9095 in-state calls only
New Hampshire 1(800)852-3388 in-state calls only	**South Dakota** 1(605)773-3656
New Jersey 1(800)792-8820 in-state calls only	**Tennessee** 1(800)525-2816
New Mexico 1(800)432-2080 in-state calls only	**Texas** 1(800)252-9240
New York 1(800)333-4114	**Utah** 1(800)541-7735 in-state calls only
North Carolina 1(800)443-9354 in-state calls only	**Vermont** 1(800)642-5119 in-state calls only
North Dakota 1(800)247-0560 in-state calls only	**Virgin Islands** 1(340)778-6311 x2338
Northern Mariana Islands 1(808)586-7299	**Virginia** 1(800)552-3402
Ohio 1(800)686-1578 in-state calls only	**Washington** 1(800)397-4422
Oklahoma 1(800)763-2828 in-state calls only	**Washington, D.C.** 1(202)739-0668
Oregon 1(800)722-4134 in-state calls only	**West Virginia** 1(877)987-4463
Pennsylvania 1(800)783-7067	**Wisconsin** 1(877)333-0202
Puerto Rico 1(877)725-4300 in-state calls only	**Wyoming** 1(800)856-4398

Durable Medical Equipment Regional Carrier (DMERC): Call about bills for durable medical equipment and a list of approved suppliers of this equipment.

If you live in:	Your DMERC is:
Illinois Indiana Maryland Michigan Minnesota Ohio Virginia Washington D.C. West Virginia Wisconsin	Adminastar Federal 1(800)270-2313 TTY/TDD: 1(317)841-4677
Alaska American Samoa Arizona California Guam Hawaii Idaho Iowa Kansas Missouri Montana Nebraska Nevada North Dakota Northern Mariana Islands Oregon South Dakota Utah Washington Wyoming	Cigna Medicare 1(800)899-7095 TTY/TDD: 1(800)970-7494
Alabama Arkansas Colorado Florida Georgia Kentucky Louisiana Mississippi New Mexico North Carolina Oklahoma Puerto Rico South Carolina Tennessee Texas Virgin Islands	Palmetto Government Benefits Administration 1(800)213-5452
Connecticut Delaware Maine Massachusetts New Hampshire New Jersey New York Pennsylvania Rhode Island Vermont	Blue Cross Blue Shield of Western New York 1(800)842-2052 TTY/TDD: 1(800)842-9519

Fiscal Intermediary: Call about Part A bills and services, hospital care, skilled nursing care, and fraud and abuse. Calls may be referred to another company that covers your claims.

Alabama
Mutual of Omaha,
1(402)351-2860

Arizona
Blue Cross Blue Shield of Arizona,
1(800)232-2345x4298
TTY/TDD: 1(602)864-4823

Colorado
Trailblazer Health Enterprises,
1(800)442-2620
TTY/TDD: 1(800)516-6684

Alaska
Premera Blue Cross Medicare,
1(425)670-1010

Arkansas
Blue Cross Blue Shield,
1(877)356-2368
TTY/TDD: 1(888)476-3009

Connecticut
Empire Medicare Services,
1(800)442-8430
TTY/TDD: 1(631)244-5101

American Samoa
Blue Cross of California,
1(808)942-2400

After December 1, 2000 United Government Services will replace Blue Cross of California. The phone number listed above will not change.

California
Blue Cross of California,
1(805)383-2038

After December 1, 2000 United Government Services will replace Blue Cross of California. The phone number listed above will not change.

Delaware
Empire Medicare Services,
1(800)442-8430
TTY/TDD: 1(631)244-5101

Fiscal Intermediary: Call about Part A bills and services, hospital care, skilled nursing care, and fraud and abuse.

Florida
Blue Cross Blue Shield,
1(904)355-8899
TTY/TDD: 1(800)754-7820

Hawaii
Blue Cross of California,
1(808)942-2400

After December 1, 2000 United Government Services will replace Blue Cross of California. The phone number listed above will not change.

Indiana
Adminastar Federal,
1(800)622-4792

Georgia
Blue Cross Blue Shield,
1(706)322-4082
TTY/TDD: 1(706)571-5454

Idaho
Medicare Northwest,
1(503)721-7000

Iowa
Cahaba Health Benefits Administration,
1(515)471-7200

Guam
Blue Cross of California,
1(808)942-2400

After December 1, 2000 United Government Services will replace Blue Cross of California. The phone number listed above will not change.

Illinois
Adminastar Federal,
1(312)938-6266

Kansas
Blue Cross Blue Shield - Part A,
1(800)445-7170
TTY/TDD: 1(800)430-8757

Fiscal Intermediary: Call about Part A bills and services, hospital care, skilled nursing care, and fraud and abuse.

Kentucky
Adminastar Federal,
1(800)999-7608
TTY/TDD: 1(502)329-8713

Maryland
Blue Cross Blue Shield of Maryland,
1(800)655-1636

Minnesota
Noridian Mutual Insurance Company,
1(800)330-5935
TTY/TDD: 1(303)858-5903

Louisiana
Trispan Health Services,
1(800)932-7644
TTY/TDD: 1(601)939-5704

Massachusetts
Associated Hospital Service of Maine,
1(888)896-4997
TTY/TDD: 1(207)822-4646

Mississippi
Trispan Health Services,
1(800)932-7644
TTY/TDD: 1(601)939-5704

Maine
Associated Hospital Service of Maine,
1(888)896-4997
TTY/TDD: 1(207)822-4646

Michigan
United Government Services,
1(313)225-8317

Missouri
Trispan Health Services,
1(800)932-7644
TTY/TDD: 1(601)939-5704

Fiscal Intermediary: Call about Part A bills and services, hospital care, skilled nursing care, and fraud and abuse.

Montana
Blue Cross Blue Shield,
1(800)447-7828 x4086
TTY/TDD: 1(800)637-8010 x4086

New Hampshire
Anthem Blue Cross Blue Shield,
1(800)522-8323

New York
Empire Medicare Services,
1(800)442-8430
TTY/TDD: 1(631)244-5101

Nebraska
Blue Cross Blue Shield,
1(402)390-1850

New Jersey
Riverbend GBA,
1(973)456-2112

North Carolina
Blue Cross Blue Shield,
1(800)685-1512 in-state calls only
TTY/TDD: 1(800)735-2962

Nevada
Blue Cross of California,
1(805)383-2038

After December 1, 2000 United Government Services will replace Blue Cross of California. The phone number listed above will not change.

New Mexico
Trailblazer Health Enterprises,
1(800)442-2620
TTY/TDD: 1(800)516-6684

North Dakota
Noridian Mutual Insurance Company,
1(800)247-2267
TTY/TDD: 1(303)858-5903

Fiscal Intermediary: Call about Part A bills and services, hospital care, skilled nursing care, and fraud and abuse.

Northern Mariana Islands
Blue Cross of California,
1(808)942-2400

After December 1, 2000 United Government Services will replace Blue Cross of California. The phone number listed above will not change.

Puerto Rico
Cooperativa De Seguros De Vida,
1(787)758-9720

Ohio
Adminastar Federal,
1(513)852-4314

Rhode Island
Blue Cross Blue Shield of Rhode Island,
1(800)662-5170
TTY/TDD: 1(888)239-3356

Oklahoma
Blue Cross Blue Shield,
1(918)560-3367

South Carolina
Blue Cross Blue Shield of South Carolina,
1(800)521-3761 in-state calls only
TTY/TDD: 1(803)935-0147

Oregon
Medicare Northwest,
1(503)721-7000

South Dakota
Cahaba Health Benefits Administration,
1(515)471-7200

Pennsylvania
Veritus Medicare Services,
1(800)853-1419
TTY/TDD: 1(800)452-8086

Tennessee
Riverbend Government Benefit Administrator,
1(423)755-5955
TTY/TDD: 1(423)763-3088

Fiscal Intermediary: Call about Part A bills and services, hospital care, skilled nursing care, and fraud and abuse.

Texas
Trailblazer Health Enterprises,
1(800)442-2620
TTY/TDD: 1(800)516-6684

Utah
Blue Cross Blue Shield,
1(801)333-2410
TTY/TDD: 1(800)346-4128

Vermont
Anthem Blue Cross Blue Shield,
1(800)522-8323

Virgin Islands
Cooperativa De Seguros De Vida,
1(787)758-9720

Virginia
United Government Services,
1(540)985-3931
TTY/TDD: 1(540)767-7103

Washington
Premera Blue Cross Medicare,
1(425)670-1010

Washington, D.C.
Mutual of Omaha,
1(402)351-2860

West Virginia
United Government Services,
1(540)985-3931
TTY/TDD: 1(540)767-7103

Wisconsin
United Government Services,
1(414)224-4954

Wyoming
Blue Cross Blue Shield,
1(888)557-2301

Regional Home Health Intermediary (RHHI): Call about questions on home health care, hospice care, and fraud and abuse.

If you live in:	Your RHHI is:
Connecticut Maine Massachusetts New Hampshire Rhode Island Vermont	Associated Hospital Service of Maine, 1(888)896-4997 TTY/TDD: 1(207)822-4646

If you live in:		Your RHHI is:
Alaska American Samoa Arizona California Guam Idaho	Nevada Northern Mariana Islands Oregon Washington	Blue Cross of California Medicare, 1(805)383-2990

If you live in:	Your RHHI is:
Hawaii	Blue Cross of California Medicare, 1(808)942-2400

If you live in:		Your RHHI is:
Colorado Delaware Iowa Kansas Maryland Missouri Montana Nebraska	North Dakota Pennsylvania South Dakota Utah Virginia Washington, D.C. West Virginia Wyoming	Cahaba Health Benefits Administration, 1(515)471-7200

Regional Home Health Intermediary (RHHI): Call about questions on home health care, hospice care, and fraud and abuse.

If you live in:	Your RHHI is:
Alabama Arkansas Florida Georgia Kentucky Louisiana Mississippi New Mexico Oklahoma South Carolina Texas	Palmetto Government Benefits Administration, 1(803)788-4660 TTY/TDD: 1(803)935-0147
Illinois Indiana North Carolina Ohio Tennessee	

If you live in:	Your RHHI is:
Michigan Minnesota New Jersey New York Puerto Rico Virgin Islands Wisconsin	United Government Services, 1(414)224-4954

Peer Review Organization (PRO): Call about quality of care concerns, filing an appeal or complaint, or for questions about your rights as a hospital patient.

Alabama Alabama Quality Assurance Foundation, 1(800)760-4550	**Arizona** Health Services Advisory Group Company, 1(800)359-9909	**Colorado** Colorado Foundation for Medical Care, Inc., 1(800)727-7086 TTY/TDD: 1(303)695-3314
Alaska PRO West, 1(800)445-6941 TTY/TDD: 1(800)251-8890	**Arkansas** Arkansas Foundation for Medical Care, Inc., 1(800)272-5528	**Connecticut** Qualidigm, 1(800)553-7590
American Samoa Mountain Pacific Quality Health Foundation, 1(800)524-6550	**California** California Medical Review, 1(800)841-1602 TTY/TDD: 1(800)881-5980	**Delaware** Quality Insights of Delaware, 1(800)422-8804 in-state calls only

Peer Review Organization (PRO): Call about quality of care concerns, filing an appeal or complaint, or for questions about your rights as a hospital patient.

Florida Florida Medical Quality Assurance, Inc., 1(800)844-0795	**Hawaii** Mountain Pacific Quality Health Foundation, 1(800)524-6550	**Indiana** Health Care Excel, Inc., 1(800)288-1499
Georgia Georgia Medical Care Foundation, 1(800)979-7217	**Idaho** PRO West, 1(800)445-6941 TTY/TDD: 1(800)251-8890	**Iowa** Iowa Foundation for Medical Care, Inc., 1(800)752-7014
Guam Mountain Pacific Quality Health Foundation, 1(800)524-6550	**Illinois** Illinois Foundation for Quality Health Care, 1(800)647-8089	**Kansas** The Kansas Foundation For Medical Care, Inc., 1(800)432-0407

Peer Review Organization (PRO): Call about quality of care concerns, filing an appeal or complaint, or for questions about your rights as a hospital patient.

Kentucky Health Care Excel, Inc., 1(800)288-1499	**Maryland** Delmarva Foundation for Medical Care, 1(800)492-5811	**Minnesota** Stratis Health, 1(800)444-3423
Louisiana Louisiana Health Care Review, Inc., 1(800)433-4958 in-state calls only	**Massachusetts** Massachusetts Peer Review Organization, Inc., 1(800)252-5533 in-state calls only	**Mississippi** Mississippi Foundation For Medical Care, Inc., 1(800)844-0600
Maine Northeast Health Care Quality Foundation, 1(800)772-0151 in-state calls only	**Michigan** Michigan Peer Review Organization, Inc., 1(800)365-5899	**Missouri** Missouri Patient Care Review Foundation, 1(800)347-1016

Peer Review Organization (PRO): Call about quality of care concerns, filing an appeal or complaint, or for questions about your rights as a hospital patient.

Montana Mountain Pacific Quality Health Foundation, 1(800)497-8232	**New Hampshire** Northeast Health Care Quality Foundation, 1(800)772-0151 in-state calls only	**New York** Island Peer Review Organization - IPRO, 1(800)331-7767
Nebraska Sunderbruch Corporation, 1(800)247-3004	**New Jersey** The Peer Review Organization of New Jersey, Inc., 1(800)624-4557 in-state calls only	**North Carolina** Medical Review Of North Carolina, Inc., 1(800)722-0468
Nevada Healthinsight, 1(800)748-6773	**New Mexico** New Mexico Medical Review Association, 1(800)279-6824	**North Dakota** North Dakota Health Care Review, Inc., 1(800)472-2902 in-state calls only

Peer Review Organization (PRO): Call about quality of care concerns, filing an appeal or complaint, or for questions about your rights as a hospital patient.

Northern Mariana Islands
Mountain Pacific Quality Health Foundation,
1(800)524-6550

Puerto Rico
Quality Improvement Professional Research Organization,
1(800)981-5062 in-state calls only

Ohio
KePRO, Inc.,
1(800)589-7337

Rhode Island
Rhode Island Quality Partners, Inc.,
1(800)662-5028

Oklahoma
Oklahoma Foundation For Medical Quality, Inc.,
1(800)522-3414 in-state calls only

South Carolina
Carolina Medical Review,
1(800)922-3089 in-state calls only

Oregon
Oregon Medical Professional Review Organization,
1(800)344-4354

South Dakota
South Dakota Foundation for Medical Care, Inc.,
1(800)658-2285

Pennsylvania
Keystone Peer Review Organization - KEPRO,
1(800)322-1914

Tennessee
Mid South Foundation For Medical Care, Inc.,
1(800)489-4633

Peer Review Organization (PRO): Call about quality of care concerns, filing an appeal or complaint, or for questions about your rights as a hospital patient.

Texas
Texas Medical Foundation,
1(800)725-8315
TTY/TDD: 1(800)725-8339

Utah
Healthinsight,
1(800)274-2290

Vermont
Northeast Health Care Quality Foundation,
1(800)772-0151 in-state calls only

Virgin Islands
Virgin Island Medical Institute, Inc.,
1(340)712-2400

Virginia
Virginia Health Quality Center,
1(800)545-3814 in-state calls only
TTY/TDD: 1(800)828-1140

Washington
PRO West,
1(800)445-6941
TTY/TDD: 1(800)251-8890

Washington, D.C.
Delmarva Foundation for Medical Care,
1(800)645-0011

West Virginia
West Virginia Medical Institute, Inc.,
1(800)642-8686x2266

Wisconsin
Medistar,
1(800)362-2320

Wyoming
Mountain Pacific Quality Health Foundation,
1(800)497-8232

State Insurance Department: Call with questions about the Medigap policies sold in your area and any insurance-related problems.

Alabama 1(800)433-3966 in-state calls only	**Illinois** 1(312)814-2427
Alaska 1(800)467-8725 in-state calls only	**Indiana** 1(800)622-4461 in-state calls only
American Samoa 1(808)586-2790	**Iowa** 1(515)281-5705
Arizona 1(800)325-2548 in-state calls only	**Kansas** 1(800)432-2484 in-state calls only
Arkansas 1(800)224-6330	**Kentucky** 1(800)595-6053
California 1(800)927-4357 in-state calls only	**Louisiana** 1(800)259-5301 in-state calls only
Colorado 1(800)930-3745 in-state calls only	**Maine** 1(800)300-5000 in-state calls only
Connecticut 1(800)203-3447 in-state calls only	**Maryland** 1(800)492-6116
Delaware 1(800)282-8611 in-state calls only	**Massachusetts** 1(617)521-7794
Florida 1(800)342-2762 in-state calls only	**Michigan** 1(877)999-6442
Georgia 1(800)656-2298 in-state calls only	**Minnesota** 1(800)657-3602 in-state calls only
Guam 1(808)586-2790	**Mississippi** 1(800)562-2957 in-state calls only
Hawaii 1(808)586-2790	**Missouri** 1(800)726-7390
Idaho 1(800)721-3272 in-state calls only	**Montana** 1(800)332-6148 in-state calls only

State Insurance Department: Call with questions about the Medigap policies sold in your area and any insurance-related problems.

Nebraska 1(800)234-7119	**Rhode Island** 1(401)222-2223
Nevada 1(800)992-0900 in-state calls only	**South Carolina** 1(800)768-3467 in-state calls only
New Hampshire 1(800)852-3416	**South Dakota** 1(605)773-3563
New Jersey 1(609)292-5360	**Tennessee** 1(800)525-2816
New Mexico 1(800)947-4722 in-state calls only	**Texas** 1(800)252-3439
New York 1(800)342-3736 in-state calls only	**Utah** 1(800)439-3805 in-state calls only
North Carolina 1(800)443-9354 in-state calls only	**Vermont** 1(800)631-7788 in-state calls only
North Dakota 1(800)247-0560 in-state calls only	**Virgin Islands** 1(340)774-7166
Northern Mariana Islands 1(808)586-2790	**Virginia** 1(800)552-7945 in-state calls only
Ohio 1(800)686-1578 in-state calls only	**Washington** 1(800)397-4422
Oklahoma 1(800)522-0071 in-state calls only	**Washington, D.C.** 1(202)727-8000
Oregon 1(800)722-4134 in-state calls only	**West Virginia** 1(800)642-9004 in-state calls only
Pennsylvania 1(877)881-6388 in-state calls only	**Wisconsin** 1(800)236-8517 in-state calls only
Puerto Rico 1(787)722-8686	**Wyoming** 1(800)438-5768 in-state calls only

State Medical Assistance Office: Call about programs to help pay medical bills for people with low incomes.

Alabama
1(800)362-1504 in-state calls only

Alaska
1(800)211-7470 in-state calls only

American Samoa
1(808)587-3521

Arizona
1(800)523-0231 out-of-state calls only
1(800)654-8713 in-state calls only

Arkansas
1(800)482-8988

California
1(800)952-5253

Colorado
1(800)221-3943

Connecticut
1(800)842-1508 in-state calls only

Delaware
1(800)372-2022 in-state calls only

Florida
1(850)488-3560

Georgia
1(800)766-4456 in-state calls only

Guam
Number Not Available

Hawaii
1(808)587-3521

Idaho
1(877)200-5441

Illinois
1(800)252-8635 in-state calls only

Indiana
1(317)232-4966

Iowa
1(800)972-2017

Kansas
1(800)766-9012

Kentucky
1(800)635-2570

Louisiana
1(888)342-6207 in-state calls only

Maine
1(800)452-1926 in-state calls only

Maryland
1(800)492-5231

Massachusetts
1(800)841-2900

Michigan
1(800)642-3195 in-state calls only

Minnesota
1(800)657-3659

Mississippi
1(800)421-2408 in-state calls only

Missouri
1(800)392-2161

Montana
1(800)362-8312

State Medical Assistance Office: Call about programs to help pay medical bills for people with low incomes.

Nebraska 1(800)430-3244	**Rhode Island** 1(401)222-7000
Nevada 1(800)992-0900	**South Carolina** 1(803)898-2500
New Hampshire 1(800)852-3345 in-state calls only	**South Dakota** 1(605)773-3495
New Jersey 1(800)356-1561 in-state calls only	**Tennessee** 1(800)342-3145
New Mexico 1(888)997-2583 in-state calls only	**Texas** 1(800)252-8263
New York 1(518)486-9057	**Utah** 1(800)662-9651 in-state calls only
North Carolina 1(800)662-7030 in-state calls only	**Vermont** 1(800)250-8427
North Dakota 1(800)755-2604	**Virgin Islands** 1(787)250-7429
Northern Mariana Islands 1(808)587-3521	**Virginia** 1(804)786-7933
Ohio 1(800)324-8680	**Washington** 1(800)562-3022
Oklahoma 1(800)522-0310 in-state calls only	**Washington, D.C.** 1(202)727-0725
Oregon 1(800)282-8096 in-state calls only	**West Virginia** 1(304)558-1700
Pennsylvania 1(800)692-7462 in-state calls only	**Wisconsin** 1(800)362-3002
Puerto Rico 1(787)250-7429	**Wyoming** 1(800)251-1269

Health Care Financing Administration (HCFA) Regional Offices: Call for information about local seminars and health fairs on Medicare health plan choices, or to report a complaint directly to HCFA.

1(617)565-1232 Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont	**1(214)767-6401** Arkansas, Louisiana, New Mexico, Oklahoma, Texas
1(212)264-3657 New Jersey, New York, Puerto Rico, Virgin Islands	**1(816)426-2866** Iowa, Kansas, Missouri, Nebraska
1(215)861-4226 Delaware, Maryland, Pennsylvania, Virginia, Washington, D.C., West Virginia	**1(303)844-4024** Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming
1(404)562-7500 Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee	**1(415)744-3602** American Samoa, Arizona, California, Guam, Hawaii, Nevada, Northern Mariana Islands
1(312)353-7180 Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin	**1(206)615-2354** Alaska, Idaho, Oregon, Washington

Office for Civil Rights: Call for information about submitting a complaint about discrimination.

- You can call toll-free 1-800-368-1019, TTY/TDD: 1-800-537-7697* (for the hearing and speech impaired).
- Look on the Internet at www.medicare.gov to get the local number for your state. Click on Helpful Contacts.

* Alaska, Idaho, Washington TTY/TDD: 1-800-362-1710 (for the hearing and speech impaired).

Your Medicare Patient Rights

If you have Medicare, you have certain guaranteed rights. You have them whether you are in the Original Medicare Plan, a **Medicare managed care plan**, or a **Private Fee-for-Service plan**.

Information: You have the right to receive easy-to-understand information about Medicare, what costs it pays, and how much you have to pay. And you have a right to know what to do if you have to file a complaint.

Emergency Care: You have the right to get emergency care when and where you need it. You don't need an OK from your health plan. If you think your health is in serious danger because you have severe pain, a bad injury, sudden illness, or an illness quickly getting much worse, you can get emergency care anywhere in the United States.

Appeals: You have the right to file an **appeal** if Medicare does not pay for a covered service you have been given, or if your health plan does not give you a service that you believe should be provided (see pages 46-47).

Treatment Choices: You have the right to know all your treatment options from your health care provider in language that is clear to you, and in a language that you understand.

Privacy: You have the right to have any personal information that Medicare collects kept private. Medicare may collect information about you as part of its regular business, such as paying your bills. When Medicare asks for this kind of information, we must tell you that the law lets us collect it, why it is being collected, whether it is required or optional, what happens if you don't give the information, and how it will be used. If you want this information call 1-800-MEDICARE (1-800-633-4227) and ask for more information about how Medicare uses personal information.

Your rights in a Medicare Managed Care Plan

- You have a right to choose a women's health specialist from your plan's list of doctors for routine and preventive health care services.
- If you have a complex or serious medical condition, you have a right to a treatment plan from your doctor which gives you enough visits to a specialist to deal with your needs.
- Medicare managed care plans cannot have rules that stop a doctor from telling you everything you need to know about your health care, including treatment options.
- You have a right to know how your plan pays its doctors. If you want to know how your plan pays its doctors, the plan must tell you in writing. You also have the right to know whether your doctor owns all or part of a health care facility. For example, if you are referred for a blood test to a lab that he or she owns.
- If you have concerns or problems with your plan which are not about payment or service requests, you have a right to file a complaint. This type of complaint is called a **grievance**. For example, if you believe your plan's hours of operation should be different, you can file a grievance. If you believe you are not getting a high quality of care, you may file a **grievance** with either your plan or with the **Peer Review Organization** (PRO) in your State (see pages 34-39).

Your Medicare Appeal Rights

You have the right to appeal any decision about your Medicare services. This is true whether you are in the Original Medicare Plan or another Medicare health plan. If Medicare does not pay for an item or service you have been given, or if you are not given an item or service you think you should get, you can appeal.

Your Appeal Rights In The Original Medicare Plan ▸

If you are in the Original Medicare Plan, you can file an appeal if you think Medicare should have paid for, or did not pay enough for, an item or service you received. If you file an appeal, ask your doctor or provider for any information related to the bill that might help your case. Your appeal rights are on the back of the Explanation of Medicare Benefits or Medicare Summary Notice that is mailed to you from a company that handles bills for Medicare. The notice will also tell you why Medicare didn't pay your bill and how you can appeal.

Appeal Rights In a Medicare Managed Care Plan or Private Fee-for-Service Plan ▸

If you are in a Medicare managed care plan or Private Fee-for-Service plan, you can file an appeal if your plan will not pay for, does not allow, or stops a service that you think should be covered or provided. If you think your health could be seriously harmed by waiting for a decision about a service, ask the plan for a fast decision. The plan must reach a decision within 72 hours.

The plan must tell you in writing how to appeal. After you file an appeal, the plan will review its decision. Then, if your plan does not decide in your favor, an independent organization that works for Medicare, not for the plan, reviews the appeal. See your plan's membership materials or contact your plan for details about your Medicare appeal rights. You may also call 1-800-MEDICARE (1-800-633-4227) to ask for more information about your rights during an appeal.

You are Protected from Unexpected Bills ▸

A doctor or supplier might give you a notice that says Medicare probably (or certainly) will not pay for a service. If you still want to get the service, you will be asked to sign an agreement that you will pay for the service yourself if Medicare does not pay for it. This is called an Advance Beneficiary Notice. Advance Beneficiary Notices are used in the Original Medicare Plan, but not in Medicare managed care plans.

If you aren't sure if Medicare was billed for the services that you got, write to the health care provider and ask for an itemized statement. This statement will list each Medicare item or service you got from your doctor, hospital, or any

other health supplier. You should get it within 30 days. Also, you can check your Explanation of Medicare Benefits or Medicare Summary Notice to see if the service was billed to Medicare.

If you are in a **Private Fee-for-Service plan**, call your plan to find out if a service or supply will be covered. The plan must tell you if you ask.

You are Protected from Discrimination ▸

Every company or agency that works with Medicare must obey the law. You cannot be treated differently because of your race, color, national origin, disability, age, or sex under certain conditions. If you think that you have not been treated fairly for any of these reasons, call the Office for Civil Rights in your State (see page 44).

You are Protected When You are in the Hospital ▸

If you are admitted to a Medicare participating hospital, you should be given a copy of *An Important Message About Medicare Rights: Admission, Discharge, and Appeals*. It explains your rights as a hospital patient. If you are not given one, ask for it. If you are in a Private Fee-for-Service plan, call your plan to find out what your protections are. They may be different.

The Message tells you:

- You have the right to get all of the hospital care that you need, and any follow-up care after you leave the hospital.
- What to do if you think the hospital is making you leave too soon.

If you have questions about this, call your **Peer Review Organization** (PRO). Their number is on the copy of *An Important Message About Medicare Rights: Admission, Discharge, and Appeals* brochure that you got when you were admitted to the hospital. You may be able to stay in the hospital at no charge while they review your case. The hospital cannot force you to leave before the PRO makes a decision.

You are Protected in a Skilled Nursing Facility ▸

A skilled nursing facility (SNF) is a Medicare-certified facility that has the staff and equipment to give **skilled nursing care** or skilled rehabilitation services and other related health services. You must meet certain conditions for skilled nursing facility care coverage, such as a 3-day hospital stay, before you are admitted. Some nursing homes give this type of skilled care.

For your protection:

- The SNF cannot make you pay anything to be admitted unless it is clear that Medicare does not cover the cost of services;
- You must be told right away if the SNF decides that you do not need the level of skilled care covered by Medicare. If you disagree with this decision, you may ask that the SNF submit a "demand bill" to Medicare for an official decision.

The SNF must submit the demand bill and cannot make you pay a deposit for services that Medicare may not cover until Medicare gives its decision.

You must pay any **coinsurance** due while the demand bill is being processed, and for the services not covered by Medicare. If you are in a Medicare managed care plan or Private Fee-for-Service plan, call your plan for information about Skilled Nursing Facility coverage.

If you have questions about SNF care, call your Fiscal Intermediary (see pages 29A-31). You may also call 1-800-MEDICARE (1-800-633-4227) and ask for a copy of *Medicare Coverage of Skilled Nursing Facility Care*.

You are Protected When Your Home Health Care Ends ▸

Home health care agencies must give you a notice that explains why and when they think Medicare will stop paying for your home health care. If you think you still need home health care, and you think Medicare should keep paying, you can ask Medicare for an official decision.

To get an official decision, you should:

- Keep getting home health care if you think you need it. Ask how much it will cost. You should talk to your doctor and family about this.
- Pay the home health agency for these services.
- Ask the home health agency to send your claim to Medicare so that Medicare will decide if it will pay.

If Medicare decides to pay, you will get back all of your payments, except for any **coinsurance** for durable medical equipment. If Medicare decides not to pay, you will get a letter that tells you how to appeal. You can always get home health care if you want to pay for it yourself. If you have questions about home health care in the Original Medicare Plan, call your Regional Home Health Intermediary (see pages 32-33). If you have questions about home health care in a Medicare managed care plan or Private Fee-for-Service plan, call your plan. You may also call 1-800-MEDICARE (1-800-633-4227) and ask for a free copy of *Medicare Home Health Services*.

Medigap Policy Protections

You may have the right to buy a **Medigap** policy, even if you are in poor health. For more information, see page 57.

You Can Help Watch Over Spending in Medicare

Most doctors and health care providers who work with Medicare are honest. There are a few who are not honest. We are working very hard with other government agencies to protect the Medicare program.

What you can do to watch over spending in Medicare ▸

With help from the honest health care providers, law enforcement, and you, Medicare is solving this problem. Medicare has sent some dishonest providers to jail. Some providers have left the Medicare program. These actions are saving money for taxpayers and protecting Medicare for the future.

You can help protect Medicare by:

- Reviewing all payment notices from Medicare for errors.
- Making sure Medicare was not billed for health care services or medical supplies and equipment you did not get.
- Not giving your Medicare claim number (on your Medicare card) to anyone, except your doctor or other Medicare health professionals. You should not send these numbers over the Internet.
- Not letting anyone, except appropriate medical health professionals, review your medical records.

How to report errors and concerns ▸

If you see a charge on your payment notice that may be wrong, call the health care provider and ask about it. If you think that a provider may be cheating or abusing Medicare, call the Medicare Carrier or Fiscal Intermediary that sent you the notice. Their phone number is printed on the front of the notice.

You can also call the Inspector General's hotline to report Medicare fraud. The hotline number is 1-800-HHS-TIPS (1-800-447-8477). Or, send a note to htips@os.dhhs.gov by e-mail. Medicare will not use your name if you ask that it not be used.

What else can I do to fight fraud?

Call your regional U. S. Administration on Aging Office and ask about programs in your community that train volunteers to detect and report fraud. Call 1-800-MEDICARE (1-800-633-4227) and ask for a free copy of the *Medicare Fraud and Abuse Fact Sheet*. You can also look on the Internet at www.medicare.gov to read or print this fact sheet.

Medicare Questions and Answers

On pages 52-65 are frequently asked Medicare questions and answers. They are grouped as follows:

Q1 - Q10 General Medicare questions, like a new Medicare card, address changes, Part B enrollment, travel, prescription drugs, Medicaid, and Private Contracts (pages 52-55).

Q11 - Q12 Other general questions about the Original Medicare Plan (page 56).

Q13 - Q16 Questions about Medigap (supplement insurance that helps fill "gaps" in Original Medicare Plan coverage) (pages 57-60).

Q17 - Q24 Other general questions about Medicare managed care plans (like an HMO) or Private Fee-for-Service plans (pages 60-62).

Q25 - Q30 Questions about mental health, nursing home, and long-term care (pages 63-65).

General Medicare Questions and Answers

Q1: How do I get a new red, white, and blue Medicare card?

A: To get a new Medicare card, call the Social Security Administration at 1-800-772-1213. They will send you a new card. If you get benefits from the Railroad Retirement Board, call your local RRB office or 1-800-808-0772.

Q2: My copy of *Medicare & You* was sent to the wrong address. How do I change my address?

A: If you need to change your address, call the Social Security Administration at 1-800-772-1213, or call your local Social Security office. They will make the change for you. If you get benefits from the Railroad Retirement Board, call your local RRB office or 1-800-808-0772.

Q3: Why aren't the Medicare premium and coinsurance rates for 2001 in this handbook?

A: The law says Medicare must send you this handbook by October each year, in time for the November period when most plans are required to accept new members. New Medicare premium and coinsurance rates were not available at the time this handbook was printed. If you get Social Security or Railroad Retirement benefits, new rates will be sent to you with your cost of living adjustment notice. You can also get the new rates after December 1, 2000 by calling 1-800-MEDICARE (1-800-633-4227), or look at www.medicare.gov on the Internet.

Q4: What if I didn't sign up for Part B when I first became eligible?

A: If you did not take Part B when you were first eligible for Medicare at age 65, you may sign up during a **General Enrollment Period**. This period runs from January 1 through March 31 of each year. **Remember, the cost of Part B may go up 10% for each 12-month period that you could have had Part B but did not take it, except in special cases (see below). You will have to pay this extra 10% for the rest of your life.**

You can sign up for Part B at your local Social Security office. If you get benefits from the Railroad Retirement Board, you can sign up at your local RRB office. Your Part B coverage will start on July 1 of that year.

Q5: How do I sign up for Part B if I or my spouse continued to work and had group health plan coverage through my or my spouse's employer or union after I first became eligible?

A: If you didn't take Part B when you were first eligible because you or your spouse was working and had group health coverage through your or your spouse's employer or union, you can sign up for Part B during a **Special Enrollment Period**.

The Special Enrollment Periods when you can sign up are:

1. Anytime you are still covered by the employer or union group health plan, through your or your spouse's **current or active** employment, or
2. During the 8 months following the month when the employer or union group plan coverage ends, or when the employment ends (whichever is first).

   If you are disabled and working (or you have coverage from a working family member), the Special Enrollment Period rules also apply.

   Most people who sign up for Part B during a Special Enrollment Period do not pay higher **premiums**. However, if you are eligible, but do not sign up during the Special Enrollment Period, the cost of Part B may go up.

Q5: Special Enrollment Period (continued)

For more information about, or to sign up for Medicare Part B, call the Social Security Administration at 1-800-772-1213, or call your local Social Security office. If you get benefits from the Railroad Retirement Board, call your local RRB office or 1-800-808-0772.

Q6: Does Medicare cover me when I travel outside of the United States?

A: The Original Medicare Plan generally does not cover care outside the United States, but some Medicare managed care plans, Private Fee-for-Service plans, and Medigap policies do. Check your insurance coverage before you travel outside the country.

Q7: Does Medicare pay for prescription drugs?

A: The Original Medicare Plan does not cover prescription drugs except in a few cases, like certain cancer drugs. Many Medicare managed care plans cover prescription drugs, up to certain dollar limits (sometimes for an extra cost). Some Medigap policies also cover prescription drugs.

Q8: If I have Medicare and Medicaid, who will pay my health care bills first?

A: For services that Medicare covers, your bill should always be sent to Medicare first. The part of the bill that Medicare does not pay will then be sent to your state Medicaid program for further payment.

Q9: Are there any times when Medicare would pay second?

A: Sometimes your other insurance pays your health care bills first and Medicare pays second. This is called Medicare Secondary Payer. Other insurance that may have to pay first includes: employer group health plan insurance under certain conditions, no-fault insurance, any liability insurance, black lung benefits, and workers' compensation. It is important that you tell your doctor or hospital that you have other insurance so they will know how to handle your bills correctly. If you have questions about who pays first, call the Coordination of Benefits Contractor (see page 24). For more information, call 1-800-MEDICARE (1-800-633-4227) and ask for a copy of *Medicare and Other Health Benefits: Your Guide to Who Pays First.*

Q10: What is a "Private Contract," and how does it work?

A: A Private Contract is an agreement between you and a doctor who has decided not to give services through the Medicare program. If you sign a private contract with your doctor:

- No Medicare payment will be made for the services you get from this doctor.
- You will have to pay whatever this doctor or provider charges you (the **limiting charge** will not apply).
- Medicare health plans (like managed care plans and Private Fee-for-Service plans) will not pay for these services.
- No claim should be submitted, and Medicare will not pay if one is submitted.
- Your Medigap policy, if you have one, will not pay anything for this service. Call your Medigap insurance company if you have any questions before you get the service.
- Many other insurance plans will not pay for the service either.

The private contract only applies to the services you get from the doctor who asked you to sign it. You cannot be asked to sign a private contract in an emergency or urgent health situation. You may want to talk with someone in your **State Health Insurance Assistance Program** before signing a private contract (see pages 26-27). You can also call 1-800-MEDICARE (1-800-633-4227) and ask for information on private contracts.

You are always free to get non-covered services on your own if you choose to pay for these services yourself. In this case, you do not have to sign a private contract and your doctor does not have to stop giving services through Medicare.

Original Medicare Plan Questions and Answers:

Q11: How are my bills paid in the Original Medicare Plan?

A: When you get services covered by the Original Medicare Plan, your provider sends the bill to a private company that handles bills for Medicare. The Fiscal Intermediary pays bills for Part A services (see pages 29A-31) and the Medicare Carrier pays bills for Part B services (see pages 25A-F). After they process the bill, you will get an Explanation of Medicare Benefits or a Medicare Summary Notice. Please check this payment notice to be sure you got all the services, medical supplies, or equipment that Medicare was billed for. If you have any questions about bills or services listed on the payment notice, call the provider and ask about it. If you disagree with what is covered or paid, you have the right to file an appeal (see page 46). If you think the provider is being dishonest, see page 50.

Q12: What is "assignment" in the Original Medicare Plan and why is it important?

A: Assignment is an agreement between Medicare and doctors and suppliers of health care equipment and supplies (like wheelchairs, oxygen, braces, and ostomy supplies). Doctors and suppliers who agree to accept assignment accept the Medicare-approved amount as payment in full. You pay the coinsurance and deductible amounts. If assignment is not accepted, charges are often higher. This means you may pay more. There is a limit on the amount your doctor can bill you. Ambulance suppliers and durable medical equipment suppliers that do not take assignment can charge you any amount. You are responsible to pay their full charges. Medicare will reimburse you later for its share of the bill. For more information about assignment, call 1-800-MEDICARE (1-800-633-4227) to get a free copy of *Does Your Doctor or Supplier Accept Assignment*?

Medigap Questions and Answers:

Q13: Do I need to buy a Medigap policy?

A: Medigap policies help pay health care costs only if you have the Original Medicare Plan. Whether you need a Medigap policy is a decision that only you can make. Depending on your health care needs and finances, you may want to continue your employee or retiree coverage, or join a Medicare managed care plan, or a Private Fee-for-Service plan.

You do not need to buy a Medigap policy if you are in a:

- Medicare managed care plan
- Private Fee-for-Service plan

In fact, it may be illegal for anyone to sell you a Medigap policy if they know you are in one of these health plans. If you have Medicaid, it is generally illegal for an insurance company to sell you a Medigap policy. For more information, call 1-800-MEDICARE (1-800-633-4227) and ask for a free copy of the *Guide to Health Insurance for People with Medicare.*

Q14: When is the best time to buy a Medigap policy?

A: The best time to buy a **Medigap** policy is during your Medigap open enrollment period. Your Medigap open enrollment period lasts for 6 months. It begins on the first day of the month in which you are both age 65 or older and enrolled in Medicare Part B.

During this period, an insurance company cannot deny you insurance coverage, place conditions on a policy (like making you wait for coverage to start), or change the price of a policy because of past or present health problems.

Important: If you don't buy a Medigap policy during your open enrollment period, you may not be able to buy the one you want, or you may be charged more for the policy. In addition, if you drop your Medigap policy, you may not be able to get it back.

Note: If you are under age 65 and disabled or have End-Stage Renal Disease (ESRD), you may not have an open enrollment period until you turn 65. However, in some states you may have other options, such as the right to buy the same Medigap policies that are sold to people under age 65.

Medigap (Q14 continued)

For more information:

- Call your State Health Insurance Assistance Program (see pages 26-27).
- Call 1-800-MEDICARE (1-800-633-4227) and ask for a free copy of the *2000 Guide to Health Insurance for People with Medicare*.

Note: If you are age 65 or older and have health coverage through an employer or union based on your or your spouse's current or active employment, you may want to wait to enroll in Medicare Part B and delay your Medigap open enrollment period (see page 53).

Q15: What situations give me the right to buy a Medigap policy after my Medigap open enrollment period ends?

A: There are certain situations involving health coverage changes when you may have the right to buy a Medigap policy after your Medigap open enrollment period ends. These are called Medigap protections because insurance companies are required by law to issue you a policy. For example:

- Your Medicare managed care plan or Private Fee-for-Service plan is leaving the Medicare program or stops giving care in your area.
- You move outside your Medicare managed care plan or Private Fee-for-Service plan's service area.
- You leave your Medicare managed care plan or Private Fee-for-Service plan because it failed to meet its contract obligations to you (for example, the marketing material was misleading or quality standards were not met).
- You are in an employer group health plan that supplements or pays some of the costs not paid by Medicare, and the plan ends your coverage.
- Your health coverage (like a Medicare managed care plan, Private Fee-for-Service plan, employer group

Medigap (Q15 continued)

health plan that supplemented or paid some of the costs not paid for by Medicare, Medicare SELECT policy, Program of All-Inclusive Care for the Elderly (PACE), or Medicare managed care demonstration project) ends through no fault of your own. For example, the company goes bankrupt.

- You dropped your Medigap policy to join a Medicare managed care plan or Private Fee-for-Service plan, or buy a Medicare SELECT policy for the first time, and then leave that plan or policy within one year after joining.
- You joined a Medicare health plan (like a Medicare managed care plan with a Medicare + Choice contract or Private Fee-for-Service plan) when you first became eligible for Medicare at age 65, and within one year of joining, you decided to leave the Medicare health plan.

In these situations, the Medigap insurance company can't deny you insurance, place conditions on a policy, or charge you more for a policy because of past or present health problems. If you think any of these situations apply to you, call your State Health Insurance Assistance Program (see pages 26-27) to make sure that you qualify and to find out which of the Medigap policies you can buy. If you are denied Medigap coverage, you should call your State Insurance Department (see pages 40-41).

For more information about Medigap protections, call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) and ask for a free copy of *Medigap Policies and Protections*. You can also look on the Internet at www.medicare.gov to read or print this booklet.

Q16: How do I get more information about Medigap policies?

A: Call 1-800-MEDICARE (1-800-633-4227) and ask for a free copy of the *2000 Guide to Health Insurance for People with Medicare*. Look at www.medicare.gov on the Internet to get information on Medigap policies in your state. Click on Medigap Compare. If you don't have a computer, your local library or senior center may be able to help you look at this information.

Medicare managed care plan and Private Fee-for-Service plan Questions and Answers:

Q17: How do I find out which plans are offered where I live, what they cost, and what extra benefits are covered?

A: Call 1-800-MEDICARE (1-800-633-4227) and ask for a free, up-to-date list of all the plans offered where you live, with more detailed information comparing extra benefits and costs.

OR

Look at www.medicare.gov on the Internet. Click on Medicare Health Plan Compare. If you do not have a personal computer, your local library or senior center may be able to help you.

Then call any plan you may be interested in. They can tell you if the plan is offered where you live and can send you up-to-date, detailed information about their extra benefits and costs.

Q18: How do I find out if my doctor or hospital belongs to a plan?

A: If you want to keep seeing your doctor when you join a plan, call and ask if he or she is in the plan and would continue to see you if you joined the plan. You can also get a list from your plan of doctors and hospitals that belong to the plan.

Q19: How can I find out how the plan rates in quality (keeps its members healthy or treats them when they are sick), or how many people disenrolled (chose to leave their plan) and how many stayed?

A: Call 1-800-MEDICARE (1-800-633-4227) and ask for quality and other information for the plans in your area.

OR

Look at www.medicare.gov on the Internet. Click on Medicare Health Plan Compare. If you do not have a personal computer, your local library or senior center may be able to help you.

Q20: Who can help me compare plans?

A: Call your State Health Insurance Assistance Program (see pages 26-27). Volunteer counselors can help you compare the Medicare health plans available to you.

Q21: What can I do if my Medicare health plan does not stay in the Medicare program?

A: If your Medicare health plan (like a Medicare managed care plan or Private Fee-for-Service plan) leaves the Medicare program, you will be sent a notice. The notice will tell you if there are other Medicare managed care plans or Private Fee-for-Service plans in your area that you can join. Or, you can always return to the Original Medicare Plan. You may be able to get a Medigap policy (see page 58). You should learn as much as you can about your choices before making a decision. No matter what you choose, you are still in the Medicare program and will get all Medicare-covered services.

Q22: Why aren't Medicare managed care plans or Private Fee-for-Service plans available where I live?

A: These Medicare health plans are offered by private companies. The companies decide which areas they will serve. Companies may decide to offer plans in your area in the future. For the most up-to-date information about Medicare health plans in your area, call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) or look at www.medicare.gov on the Internet.

Q23: What is a "medical emergency"? How do I get emergency care?

A: A medical emergency is when you believe that your health is in serious danger -- when every second counts. You may have severe pain, a bad injury, sudden illness, or an illness quickly getting much worse. All Medicare managed care plans must allow you to get emergency care whenever you need it from any provider in the United States. You do not need permission from your primary care doctor first. Your plan must pay for emergency care. If you get a bill, give it to the plan to pay. If your plan does not pay for your emergency care, you have the right to **appeal** (see page 47).

Q24: What is "urgently needed care"? How do I get urgently needed care?

A: Urgently needed care is care you need for a sudden illness or injury that is not a medical emergency. In a Medicare managed care plan, you get urgently needed care from your primary care doctor. However, if you are out of the plan's service area and cannot wait until you return home, your plan must pay for urgently needed care. If it does not, you have the right to **appeal** (see page 47).

Special Care Questions and Answers:

Q25: Does Medicare cover mental health care?

A: If you are in the Original Medicare Plan, Part A covers inpatient mental health care, including room, meals, nursing, and other related services and supplies. Part B covers mental health services generally given outside a hospital, including visits with a doctor, clinical psychologist, clinical social worker, and lab tests (see page 8). For more information about Medicare coverage for mental health care, call 1-800-MEDICARE (1-800-633-4227) and ask for a free copy of *Medicare and your Mental Health Benefits*, or look at www.medicare.gov on the Internet.

If you are in a Medicare managed care plan or a Private Fee-for-Service plan, read your plan materials or call the plan to learn about their coverage of mental health care. You must get at least the same coverage as provided by Part A and Part B of the Original Medicare Plan.

Q26: Does Medicare pay for care in a nursing home?

A: Usually, no. Most nursing home care is custodial care. This is different than what Medicare covers. Medicare Part A only covers **skilled care** given in a certified skilled nursing facility. You must meet certain conditions and coverage is limited (see page 6).

Skilled care includes nursing or rehabilitation therapies given by skilled health care personnel such as registered nurses, licensed practical and vocational nurses, physical and occupational therapists, speech pathologists, and audiologists.

For more information about Medicare's coverage of skilled care, call 1-800-MEDICARE (1-800-633-4227) and ask for a free copy of *Medicare Coverage of Skilled Nursing Facility Care*, or look at www.medicare.gov on the Internet.

Q27: What is long-term care?

A: Long-term care is different from traditional medical care. Someone with a physical illness, a disability, or a memory or thought problem (such as Alzheimer's disease) often needs long-term care. Long-term care is made up of many different services to help people with chronic conditions overcome limitations that keep them from being independent. Long-term care may include custodial care, which is help with activities of daily living (such as shopping, bathing, and dressing). Long-term care can also include home health care, respite care, adult day care, care in a nursing home, and care in an assisted living facility. Long-term care may also include special services that help coordinate and monitor your long-term care services.

Q28: Does Medicare pay for long-term care?

A: No. Generally, Medicare only covers care that is both **medically necessary** and covered under Part A (hospital insurance) and Part B (medical insurance). You must meet certain conditions for Medicare to cover skilled nursing facility, home health, and hospice care. Medicare does not cover custodial care.

Q29: What is long-term care insurance?

A: Long-term care insurance is one way you may pay for long-term care. This type of insurance will pay for some or all of your long-term care. Long-term care insurance is relatively new. It was introduced in the 1980s as nursing home insurance, but it has changed a lot and now covers much more than nursing home care.

For more information about long-term care insurance, get a copy of *A Shopper's Guide to Long-Term Care Insurance* from your State Insurance Department, or write to the National Association of Insurance Commissioners, 120 W. 12th Street, Suite 1100, Kansas City, MO 64105-1925.

Q30: How can I find out about the nursing homes in my area?

A: You can get important information on the Internet at www.medicare.gov about the nursing homes in your area. Click on Nursing Home Compare for information and nursing home inspection reports for all the Medicare and Medicaid-certified nursing homes in the country. If you don't have a computer, your local library or senior center may be able to help you look at this information. You can also call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) and ask for a free copy of *Your Guide to Choosing a Nursing Home.*

Free Medicare and Related Booklets

Medicare has many booklets to help you learn about the program. This handbook contains basic information that everyone with Medicare needs to know. Other booklets can give you more details about topics that are of interest to you. Medicare will continue to add new booklets to get you the information you need.

How do I get these booklets?

You can:

1. Call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) and ask for a free copy of the booklet you want.

2. Look on the Internet at www.medicare.gov and click on Publications. You can read or print out these booklets.

What booklets are available?

About Basic Medicare Information:

- Medicare & You 2001

You can get free copies of this handbook in:

- English print (like this one)
- Spanish print
- English large print
- Spanish large print
- English audiotape
- Spanish audiotape
- Braille

About Services Medicare Covers:

- Medicare and Your Mental Health Benefits **New!**
- Medicare Coverage of Kidney Dialysis and Kidney Transplant Services **New!**
- Medicare Coverage of Skilled Nursing Facility Care **New!**
- Medicare Coverage For Second Surgical Opinion
- Medicare Home Health Care Services
- Medicare Hospice Benefits
- Medicare Preventive Services

What booklets are available? (continued)

About Health Care Choices:
- Choosing a Doctor **New!**
- Choosing a Hospital **New!**
- Choosing Treatments **New!**
- Your Guide to Choosing a Nursing Home
- Private Contracts Fact Sheet
- Nursing Homes Fact Sheet

About Medicare Health Plan Choices and Supplemental Coverage:
- Health Plan Comparison Information (with quality data)
- Learning about Medicare Health Plans
- 2000 Guide to Health Insurance for People with Medicare
- Your Guide to Private Fee-for-Service Plans
- Your Guide to Medicare Medical Savings Accounts
- Worksheet for Comparing Medicare Health Plans

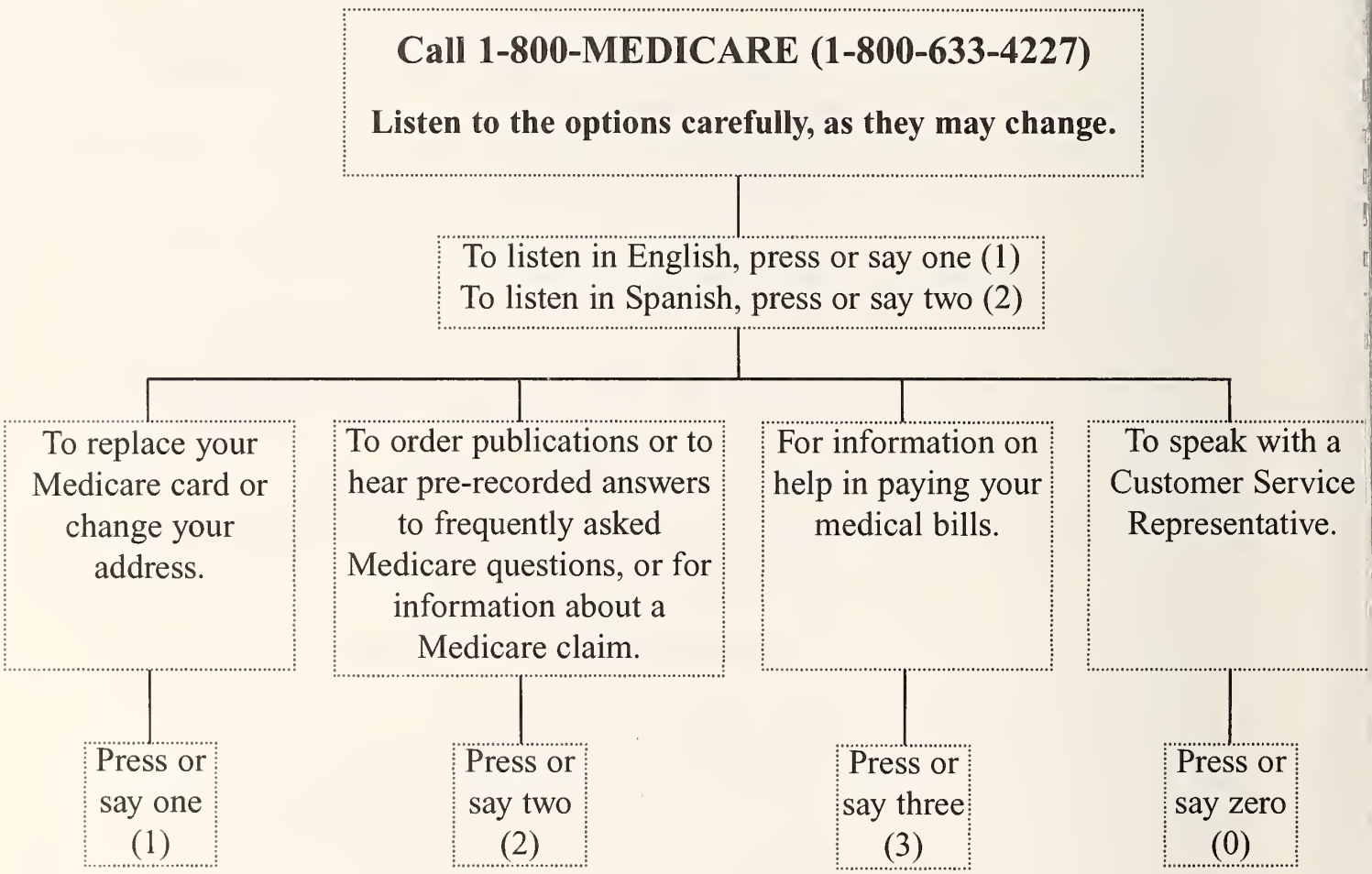
About Your Rights and Protections:
- Medicare Appeals and Grievances (Complaints)
- Medicare Fraud and Abuse
- Medicare Patient Rights
- Medigap Policies and Protections

About Costs and Payment:
- Do You Need Help to Pay Health Care Costs?
- Does Your Doctor or Supplier Accept Assignment?
- Medicare and Other Health Benefits: Your Guide to Who Pays First **New!**
- Your Guide to the Outpatient Prospective Payment System **New!**

Note: Many of these booklets are available in Audiotape (English and Spanish), Braille, Large Print, and Spanish. Some booklets are also available in Chinese.

Call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048) to:

- Get more help with your Medicare questions.
- Order quality and other information about the Medicare health plans in your area.
- Listen to recorded questions and answers on topics such as Medicare health plan choices.
- Order Medicare publications. (Some are available in Audiotape, Braille, Large print, and Spanish.)


Call 1-800-MEDICARE (1-800-633-4227)
Listen to the options carefully, as they may change.
To listen in English, press or say one (1)
To listen in Spanish, press or say two (2)
To replace your Medicare card or change your address.
To order publications or to hear pre-recorded answers to frequently asked Medicare questions, or for information about a Medicare claim.
For information on help in paying your medical bills.
To speak with a Customer Service Representative.
Press or say one (1)
Press or say two (2)
Press or say three (3)
Press or say zero (0)

Important Notes About 1-800-MEDICARE

- If you are hearing or speech impaired, call the TTY/ TDD line toll-free at 1-877-486-2048 for these options.
- Once you have called 1-800-MEDICARE, you can either press the numbers listed or just say the numbers to request what you want.
- You can hear a recording with answers to frequently asked questions, and can order publications 24 hours a day, 7 days a week.
- You can talk with a Customer Service Representative between 8:00 a.m. and 4:30 p.m. in your time zone, Monday through Friday.

Appeal - An appeal is a special kind of complaint you make if you disagree with any decision about your health care services. For example, if Medicare doesn't pay for a service you got. This complaint is made to your Medicare health plan or the Original Medicare Plan. There is usually a special process you must use to make your complaint.

Benefit Period - The way that Medicare measures your use of hospital and skilled nursing facility services. A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

Coinsurance - The percent of the Medicare-approved amount that you have to pay after you pay the deductible for Part A and/or Part B. In the Original Medicare Plan, the coinsurance payment is a percentage of the cost of the service (like 20%).

Copayment - In some Medicare health plans, the amount that you pay for each medical service you get, like a doctor visit. A copayment is usually a set amount you pay for a service. For example, this could be $5 or $10 for a doctor visit. Copayments are also used for some hospital outpatient services in the Original Medicare Plan.

Deductible - The amount you must pay for health care, before Medicare begins to pay, either each benefit period for Part A, or each year for Part B. These amounts can change every year.

End-Stage Renal Disease - Kidney failure that is severe enough to require lifetime dialysis or a kidney transplant.

General Enrollment Period (GEP) - The GEP is January 1 through March 31 of each year. If you enroll in Part B or Part A (if you don't get it automatically without paying a premium) during the GEP, your coverage starts on July 1.

Grievance - A complaint about the way your Medicare health plan is giving care. For example, you may file a grievance if you have problems with the cleanliness of the health care facility, calling the plan, staff behavior, or operating hours. A grievance is not the same as an appeal, which is the way to deal with a complaint about a treatment decision or a service that is not covered (see **Appeal**).

Inpatient Care - Health care that you get when you stay overnight in a hospital.

Limiting Charge - The highest amount of money you can be charged for a covered service by doctors and other health care providers who don't accept assignment. The limit is 15% over Medicare's approved amount. The limiting charge only applies to certain services and does not apply to supplies or equipment.

Medicaid - A joint Federal and State program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically Necessary - Services or supplies that:

- are proper and needed for the diagnosis or treatment of your medical condition;
- are provided for the diagnosis, direct care, and treatment of your medical condition;
- meet the standards of good medical practice in the medical community of your local area; and
- are not mainly for the convenience of you or your doctor.

Medicare-Approved Amount - The fee Medicare sets as reasonable for a covered medical service. This is the amount a doctor or supplier is paid by you and Medicare for a service or supply. It may be less than the actual amount charged by a doctor or supplier. The approved amount is sometimes called the "Approved Charge."

Medicare Managed Care Plan - These are health care choices in some areas of the country. In most plans, you can only go to doctors, specialists, or hospitals on the plan's list. Plans must cover all Medicare Part A and Part B health care. Some plans cover extras, like prescription drugs. Your costs may be lower than in the Original Medicare Plan.

Medicare Medical Savings Account (MSA) - A Medicare health plan option made up of two parts. One part is a Medicare MSA Health Insurance Policy with a high deductible. The other part is a special savings account where Medicare deposits money to help you pay your medical bills.

Medigap - A Medicare supplemental health insurance policy sold by private insurance companies to fill "gaps" in Original Medicare Plan coverage. Except in Massachusetts, Minnesota, and Wisconsin, there are 10 standardized policies labeled Plan A through Plan J. Medigap policies only work with the Original Medicare Plan.

Peer Review Organization (PRO) - Groups of practicing doctors and other health care experts paid by the Federal Government to monitor and improve the care given to Medicare patients. They must review your complaints about the quality of care provided by inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare managed care plans, and ambulatory surgical centers.

Premium - What you pay monthly for health care coverage to Medicare, an insurance company, or a health care plan.

Primary Care Doctor - A doctor who is trained to give you basic care. This includes being the first one to check on health problems and coordinating your preventive health care with other doctors, specialists, and therapists. In many Medicare managed care plans, you must see your primary care doctor before you can see any other health care provider. (See Medicare Managed Care Plan.)

Private Fee-for-Service Plan - A private insurance plan that accepts Medicare beneficiaries. You may go to any doctor or hospital you want. The insurance plan, rather than the Medicare program, decides how much it will pay and what you pay for the services you get. You may pay more for Medicare-covered benefits. You may have extra benefits the Original Medicare Plan does not cover.

Quality - Quality is how well the health plan keeps its members healthy or treats them when they are sick. Good quality health care means doing the right thing at the right time, in the right way, for the right person--and getting the best possible results.

Referral - An OK from your primary care doctor for you to see a specialist or get certain services. In many Medicare managed care plans, you need to get a referral before you can get care from anyone except your primary care doctor. If you do not get a referral first, the plan may not pay for your care.

Reserve Days - Sixty days that Medicare will pay for when you are put in a hospital for more than 90 days. These 60 reserve days can be used only once during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance amount ($388 in 2000).

Skilled Nursing Facility Care* - A level of care that must be given or managed by licensed health care professionals and is under the general direction of a doctor. All of your needs are taken care of with this type of service, including getting direct services. As long as you need skilled care, it makes no difference whether your illness is acute, chronic, or terminal. Medicare does not cover unskilled (custodial) care, except when it is given in addition to Medicare-covered skilled care.

Special Enrollment Period (SEP) - A set time when you can sign up for Medicare Part B if you did not take Part B during the Initial Enrollment Period, because you or your spouse currently work and have group health plan coverage through the employer or union. You can sign up at any time you are covered under the group plan. If the employment or group health coverage ends, you have 8 months to sign up. The 8-month SEP starts the month after the employment ends or the group health coverage ends, whichever comes first.

State Health Insurance Assistance Program (SHIP) - A state organization that gets money from the Federal Government to give free health insurance counseling and assistance to people with Medicare.

* This definition in whole or in part was used with permission from Walter Feldesman, Esq., *Dictionary of Eldercare Terminology 2000.*

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National Medicare Handbook; with a listing of important phone numbers for your area.

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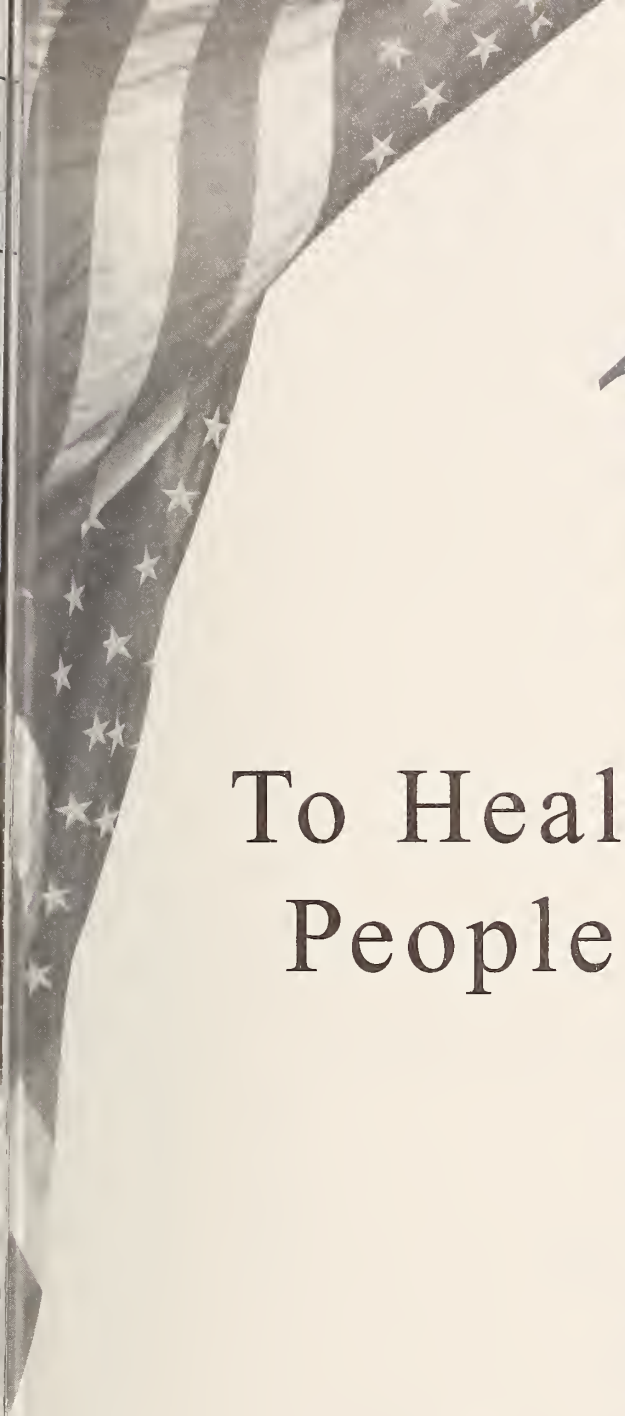

2000 Guide

To Health Insurance for People with Medicare

A Guide For:

- Buying a Medigap Policy
- Using a Medigap Policy
- Other Kinds of Health Insurance

Get the basics on pages 3-21.

HEALTH CARE FINANCING ADMINISTRATION

The Federal Medicare Agency

How To Use This Guide (continued)

* At the time this Guide was printed, no private insurance companies were offering these types of plans. Call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) to get the most current information about these types of plans.

Do I need a Medigap policy?

Medigap policies only help pay health care costs if you have the Original Medicare Plan.

You do not need to buy a Medigap policy if you are in a:

- Medicare managed care plan
- Private Fee-for-Service plan
- Medicare Medical Savings Account Plan*
- Religious Fraternal Benefit Plan*

In fact, it may be illegal for anyone to sell you a Medigap policy if they know you are in one of these health plans.

If you have Medicaid, it is illegal for an insurance company to sell you a Medigap policy (except in certain situations), see page 79.

How should I use this Guide?

Read over "A Quick Look At Medicare" in Part 1. This will help you understand what Medicare does and does not cover.

Use the chart on page 10 to help get an idea of the benefits that Medigap policies cover. These benefits are described in more detail on pages 24-27 in Part 2.

Use Part 2 to get more information about Medigap insurance and other kinds of insurance.

How To Use This Guide (continued)

Do I have to buy more insurance?

The choice to buy more insurance is yours. If you have the Original Medicare Plan, you don't have to buy any additional insurance. But remember, even with a Medigap policy there are still costs that the Original Medicare Plan doesn't cover. More insurance is the best way to be sure that you can cover your other medical costs.

Part 1 - Medigap Basics ▸

A Quick Look At Medicare .....Pages 4-8

Buying a Medigap Policy .....Pages 9-17

Using a Medigap Policy .....Page 18

Other Kinds of Health Insurance .....Pages 19-20

Summary of Medigap Basics ..... Page 21

Remember, Part 2 has more details on each of these topics.

A Quick Look At Medicare

What is Medicare?

Medicare is a health insurance program for:

- People 65 years of age and older.
- Some disabled people under 65 years of age.
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

There are two parts of Medicare:

Part A - Hospital Insurance

Helps Pay For: Care in hospitals, some skilled nursing facilities, hospice, and some home health care (see chart on page 97).

Cost: For most people, Part A is premium-free. This means most people do not have to pay a monthly payment (premium) for Part A because they (or a spouse) paid Medicare taxes while they were working.

Part B - Medical Insurance

Helps Pay For: Doctors, outpatient hospital care, and some other medical services that Part A does not cover, such as the services of physical and occupational therapists, and some home health services (see charts on pages 98-99).

Cost: You pay the Medicare Part B premium of $45.50 per month in 2000. Premiums can change yearly. In some cases, this amount may be higher if you did not choose Part B when you first became eligible for Medicare.

Terms in red are defined on pages 100-103.

How do I get Part B?

You are automatically eligible for Part B if you are eligible for premium-free Part A. You are also eligible if you are a United States citizen or permanent resident age 65 or older.

A Quick Look At Medicare (continued)

Just before you turn 65 years old, you have to decide whether or not to take Part B. You should keep in mind that the cost of Part B may go up 10% for each 12-month period that you could have had Part B but did not take it, except in special cases (see "Special Enrollment Period"). **You will have to pay this extra 10% for the rest of your life**. If you choose to get Part B, the monthly premium is taken out of your Social Security, Railroad Retirement, or Civil Service Retirement payment. If you don't get any of these payments, you are billed by Medicare every 3 months.

If you didn't take Part B when you were first eligible, you can sign up during 2 enrollment periods. The two enrollment periods are:

General Enrollment Period

The General Enrollment Period is from January 1 through March 31 of each year. You can sign up for Part A or Part B at your local Social Security Administration office. Your Part B coverage will start on July 1 of that year.

Special Enrollment Period

If you didn't take Part B when you were first eligible because you or your spouse were working and had group health plan coverage through your or your spouse's employer or union, you can sign up for Part B during a Special Enrollment Period.

You can sign up:

1. Anytime you are still covered by the employer or union group health plan through your or your spouse's **current or active** employment, or

2. Within 8 months of the date when the employer or union group health plan coverage ends, or when the employment ends (whichever is first).

If you are disabled and working (or you have coverage from a working family member), the

A Quick Look At Medicare (continued)

Special Enrollment Period rules also apply.
Most people who sign up for Part B during a Special Enrollment Period do not pay higher premiums. However, if you are eligible, but do not sign up for Part B during the Special Enrollment Period, the cost of Part B may go up.

Call the Social Security Administration at 1-800-772-1213 (TTY: 1-800-325-0778) for more information about signing up for Medicare Parts A and B.

What are my Medicare health plan choices?

Depending on where you live, you may have three choices: the Original Medicare Plan, a Medicare managed care plan, or a Private Fee-for-Service plan.

The Original Medicare Plan (also known as fee-for-service)

The Original Medicare Plan is available everywhere in the United States. It is the way most people get their Medicare Part A and Medicare Part B health care. You may go to any doctor, specialist, or hospital that accepts Medicare. You pay your share on a pay-per-visit basis, and Medicare pays its share. Some things are not covered, like most prescription drugs, cosmetic surgery, and routine physical exams.

Note: Medigap policies **only help** pay health care costs if you have the Original Medicare Plan.

Medicare Managed Care Plans (like an HMO)

These are health plans available in many areas of the country. In most plans, you can only go to doctors, specialists, or hospitals on the plan's list. Plans must cover all Medicare Part A and Medicare Part B health care benefits. Some plans cover extras, like prescription drugs. Your costs may be lower than in the Original Medicare Plan.

Note: Medigap policies **don't help** pay health care costs if you are in a Medicare managed care plan.

A Quick Look At Medicare (continued)

Private Fee-for-Service Plans

This is a new health care choice that will become available in some areas of the country in 2000.

A Private Fee-for-Service plan is a Medicare health plan offered by a private insurance company. It is not the same as the Original Medicare Plan which is offered by the federal government. In a Private Fee-for-Service plan, Medicare pays a set amount of money every month to the private company to provide health care coverage to people with Medicare on a pay-per-visit arrangement. The insurance company, rather than the Medicare program, decides how much you pay for the services you get.

Note: Medigap policies **don't help** pay health care costs if you are in a Private Fee-for-Service plan.

For more information about this type of plan, call 1-800-MEDICARE (1-800-633-4227, TTY/TDD 1-877-486-2048 for the hearing and speech impaired) and ask for a free copy of *Your Guide to Private Fee-for-Service Plans* or use a computer to look on the Internet at www.medicare.gov.

If I am in the Original Medicare Plan, why would I buy a Medigap policy?

If you are in the Original Medicare Plan, a Medigap policy may help you:

- Lower your out-of-pocket costs.
- Get more health insurance coverage.

You may want to buy a Medigap policy because Medicare does not pay for all of your health care. There are "gaps" or costs that you must pay in Original Medicare Plan coverage. The chart on page 8 explains these gaps and gives examples.

You don't need a Medigap policy if you are in a Medicare health plan other than the Original Medicare Plan.

Gaps in the Original Medicare Plan

	Why there's a Gap	Examples of Gaps
1. What you pay for Medicare covered services	The law requires you to pay for part of some Medicare coverage	■ Part A deductible for each benefit period ■ Part B deductible of $100 per year ■ 20% coinsurance for most Part B covered services
2. What is covered in part by Medicare	Medicare only pays for part of some services	■ Home health care that does not meet certain required conditions ■ Costs for skilled nursing facility care for days 21-100 in the benefit period (see page 97). ■ First three pints of blood each year
3. What is not covered by Medicare	Medicare doesn't cover some medical costs	■ Outpatient prescription drugs ■ Eyeglasses ■ Hearing aids ■ Routine physical exams ■ Emergency care outside the U.S. ■ Custodial care ■ Orthopedic shoes ■ Cosmetic surgery ■ Dental care ■ Dentures ■ Routine foot care

What you have to pay to cover the gaps shown on the chart will depend on:

- Whether your doctor or supplier accepts "assignment" or takes Medicare's approved amount as payment in full (see page 100).
- How often you need health care.
- What type of health care you need.
- Whether you buy a Medigap policy.
- What Medigap policy you buy.
- Whether you have other health insurance coverage.

Buying a Medigap Policy

"The thing about Medigap is you can take as much or as little coverage as you want. When I had knee surgery, my Medigap policy paid much of the costs that Medicare did not pay for."

Mark
Providence, Rhode Island

The chart on page 10 lists the benefits in the 10 standardized Medigap plans.

If you live in Massachusetts, Minnesota, or Wisconsin, see pages 94-96.

Remember, terms in red are defined on pages 100-103.

What is a Medigap policy and how does it work?

A Medigap policy is sold by private insurance companies to fill the "gaps" in Original Medicare Plan coverage. The front of the Medigap policy must clearly identify it as "Medicare Supplement Insurance." In all but three states (Minnesota, Massachusetts, and Wisconsin), there are 10 standardized Medigap plans called "A" through "J." Each plan has a different set of standard benefits.

Medicare SELECT is a type of Medigap insurance policy. If you buy a Medicare SELECT policy, you are buying one of the 10 standardized Medigap plans A through J (see page 23).

When you buy a Medigap policy you pay a premium to the insurance company. As long as you pay your premium, policies bought after 1990 are automatically renewed each year. This means that your coverage continues year after year as long as you pay your premium. You still must pay your monthly Medicare Part B premium.

What do Medigap policies cover?

Each standardized Medigap policy must cover basic (core) benefits (see the chart on page 10). Medigap policies pay most, if not all, of the Original Medicare Plan coinsurance amounts. These policies may also cover the Original Medicare Plan deductibles. Some of the policies cover extra benefits to fill more of the gaps in your coverage, like prescription drugs. If you live in Massachusetts, Minnesota, or Wisconsin, see pages 94-96.

Chart of Ten Standardized Medigap Plans A through J

Medigap policies (including Medicare SELECT) can only be sold in 10 standardized plans. This chart gives you a quick and easy look at all the Medigap plans and what benefits are in each plan. For more details about Medigap plan benefits, see pages 24-27.

Basic Benefits: Included in All Plans.

- Inpatient Hospital Care: Covers the Part A coinsurance and the cost of 365 extra days of hospital care during your lifetime after Medicare coverage ends.
- Medical Costs: Covers the Part B coinsurance (generally 20% of the Medicare-approved payment amount).
- Blood: Covers the first 3 pints of blood each year.

A	B	C	D	E	F*	G	H	I	J*
Basic Benefit	Basic Benefit	Basic Benefit	Basic Benefit	Basic Benefit	Basic Benefit	Basic Benefit	Basic Benefit	Basic Benefit	Basic Benefit
		Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible				Part B Deductible
					Part B Excess (100%)	Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery			At-Home Recovery		At-Home Recovery	At-Home Recovery
							Basic Drug Benefit ($1,250 Limit)	Basic Drug Benefit ($1,250 Limit)	Extended Drug Benefit ($3,000 Limit)
				Preventive Care					Preventive Care

* Plans F and J also have a high deductible option (see page 11). Call your State Insurance Department for more information (see pages 86-87). Note: This chart does not apply if you live in Massachusetts, Minnesota, or Wisconsin (see pages 94-96).

Buying a Medigap Policy (continued)

Do any Medigap policies cover prescription drugs?

Yes. Plans H and I offer the "basic" prescription drug benefit. Plan J offers the "extended" prescription drug benefit (see chart below).

		After you pay...	The plan pays...
Plans H and I ▶	Basic Prescription Drug Benefit	$250 per year deductible	50% of prescription drug costs up to a maximum of $1,250 per year. (For more information, see page 26.)
Plan J ▶	Extended Prescription Drug Benefit	$250 per year deductible	50% of prescription drug costs up to a maximum of $3,000 per year. (For more information, see pages 26 and 27.)

What is a "high deductible option" and how does it affect my costs?

Insurance companies may offer a "high deductible option" on Plans F and J. If you choose this option, you must pay a $1,530 deductible for the year 2000 before the plan pays anything. This is an increase for all high deductible plans that were bought before 2000. This amount can go up each year.

High deductible option policies often cost less but, if you get sick, your out-of-pocket costs will be higher and you may not be able to change plans.

In addition to the $1,530 deductible that you must pay for the high deductible option on plans F and J, you must also pay deductibles for prescription drugs ($250 per year for Plan J) and foreign travel emergency ($250 per year for Plans F and J).

Remember, terms in red are defined on pages 100-103.

Buying a Medigap Policy (continued)

What is not covered by Medigap policies?

Medigap policies do not cover:

- Long-term care
- Vision or dental care
- Hearing aids
- Private-duty nursing
- Unlimited prescription drugs

What should I think about before buying a Medigap policy?

- How much am I spending on health care?
- What are my health care dollars spent on?
- Which Medigap benefits do I need?
- How much can I afford to spend on premiums?
- What will my future health care costs be? Remember, you may need more health care as you get older.

"Before I bought my first policy, I looked at different insurance companies and compared what they pay for and how much it was going to cost me to join. That way, I was able to see the difference between what I pay now for certain medical costs and what I would pay with a Medigap policy."

Abigail
Wilmington, North Carolina

Buying a Medigap Policy (continued)

How can I get information on Medigap policies in my state?

You can get information about Medigap policies in your state by calling:

- Your State Insurance Department to find out what Medigap polices are available in your state and which companies sell them (see pages 86-87); or
- Your State Health Insurance Assistance Program to get free counseling to help you decide which policy is best for you (see pages 88-89).

New in 2000! ▶

You can also use a computer to find information on and compare Medigap policies offered in your state. Look on the Internet at www.medicare.gov and click on "Medigap Compare." This website has information on:

- Which Medigap policies are sold in your state.
- How to shop for a Medigap policy.
- What the policies must cover.
- How insurance companies decide what to charge you for a Medigap policy premium.
- Your Medigap rights and protections.

If you don't have a computer, your local library or senior center may be able to help you look at this information.

Buying a Medigap Policy (continued)

When is the best time to buy a Medigap policy?

The best time to buy a Medigap policy is during your Medigap open enrollment period.

Your Medigap open enrollment period lasts for 6 months. It begins on the first day of the month in which you are both:

- Age 65 or over; **and**
- Enrolled in Medicare Part B.

During this period, an insurance company cannot deny you insurance coverage, place conditions on a policy (like making you wait for coverage to start), or change the price of a policy because of past or present health problems (see the "open enrollment" Example on page 36).

If you buy a policy during your Medigap open enrollment period, the insurance company must shorten the waiting period for pre-existing conditions by the amount of previous health coverage (creditable coverage) you have (see page 38).

If you are disabled or have End-Stage Renal Disease, see page 39.

Should I start my Medigap open enrollment period if I am age 65 or over and still working?

You may want to wait to enroll in Medicare Part B if you have health coverage through an employer or union based on your or your spouse's **current or active** employment. Your Medigap open enrollment period won't start until after you sign up for Medicare Part B. Remember, once you're age 65 or older **and** enrolled in Medicare Part B, the Medigap open enrollment period starts and cannot be changed.

Remember, terms in red are defined on pages 100-103.

Buying a Medigap Policy (continued)

"I checked all the insurance companies in my state...that paid the deductible and also had prescription drug coverage, because I take a lot of prescriptions."

Kristina
Richmond, Virginia

How do I shop for a Medigap policy?

Quick Shopping Tips

- First, review the 10 standardized Medigap plans and choose the type of plan that has the benefits you want.
- Shop carefully. Call different insurance companies about the plan you want and compare cost and service before you buy.
- **Do not** buy more than one Medigap policy at a time.
- **Do not** let a salesperson rush you into buying a policy.
- **Do not** pay cash. Pay by check, money order, or bank draft made payable to the insurance company, not to the agent or anyone else.

Caution: Before you shop for a Medigap policy, look at more detailed shopping information on pages 27-35.

What are Medigap protections?

Medigap protections are special rights you have to buy a Medigap policy in addition to your Medigap open enrollment period. You have these rights only in certain situations (see pages 16-17). Medigap protections are important because **if you do not buy a Medigap policy during your open enrollment period, and you don't have these protections**, an insurance company may be able to refuse to sell you a policy, or may charge you more for a policy. Also, if you drop your Medigap policy, you may not be able to get it back unless you have these protections.

Buying a Medigap Policy (continued)

What situations give me the right to buy a Medigap policy after my Medigap open enrollment period ends?

There are certain situations involving health coverage changes where you may have the right to buy a Medigap policy after your Medigap open enrollment period ends. These are also called "guaranteed issue" rights because insurance companies are required by law to issue you a policy. For example:

- Your Medicare managed care plan or Private Fee-for-Service plan is leaving the Medicare program or stops giving care in your area (see Situation #1 on pages 43-47); or
- You move outside your Medicare health plan's service area (see Situation #2 on pages 47-50); or
- You leave the Medicare health plan because it failed to meet its contract obligations to you (see Situation #2 on pages 47-50); or
- You are in an employer group health plan that supplemented or paid some of the costs not paid for by Medicare, and the plan ends your coverage (see Situation #2 on pages 47-50); or
- Your health coverage (like a Medicare managed care plan, Private Fee-for-Service plan, Medicare SELECT policy, Programs of All-Inclusive Care for the Elderly (PACE), or Medicare managed care demonstration project) ends through no fault of your own. For example, the company goes bankrupt (see Situation #2 on pages 47-50); or
- You dropped your Medigap policy to join a Medicare managed care plan, or Private Fee-for-Service plan, or buy a Medicare SELECT policy for the first time, and then leave that plan or policy

For more information on PACE, see pages 19 and 76.

Remember, terms in red are defined on pages 100-103.

Buying a Medigap Policy (continued)

within one year after joining (see Situation #3 on pages 51-54); or

- You joined a Medicare health plan (like a Medicare managed care plan or Private Fee-for-Service plan) when you first became eligible for Medicare at age 65, and within one year of joining, you decided to leave the Medicare health plan (see Situation #4 on pages 55-57).

In these situations, the Medigap insurance company can't deny you insurance, place conditions on a policy, or charge you more for a policy because of past or current health problems. If you think any of these situations applies to you, call your State Health Insurance Assistance Program (see pages 88-89) to make sure that you qualify. If you are denied Medigap coverage, you should call your State Insurance Department (see pages 86-87).

If you live in Massachusetts, Minnesota, or Wisconsin, you have the right to buy a Medigap policy that is similar to the standardized policies you can buy in other states. For more information, call your State Insurance Department (see pages 86-87).

Note: If you are under age 65 and disabled or have End-Stage Renal Disease, you may have the right to buy certain Medigap policies that are sold to people under age 65 (see pages 39-40). For more information, call your State Health Insurance Assistance Program (see pages 88-89).

Using a Medigap Policy

How do my bills get paid if I have a Medigap policy?

Information on how your bills are paid should come with your Medigap policy. Your insurance company can also tell you how your claims are filed.

Generally, when you get health care covered by both Medicare and your Medigap policy, you will not have to file a separate claim to the Medigap insurance company. The Medicare Carrier that handles Medicare claims for your area will send your claims to the Medigap insurance company. To find out more about Medigap claims, see page 62.

Will Medicare and Medigap pay if I sign a private contract with my doctor?

A private contract is an agreement between you and a doctor who has decided not to give services through the Medicare program. By signing a private contract, you agree to pay whatever the doctor charges you and there is no limit on what can be charged. Medicare and Medigap will **not** pay for any health care service you get from that doctor. (For more detailed information about private contracts, see page 63.) You may want to talk with someone in your State Health Insurance Assistance Program before signing a private contract with your doctor (see pages 88-89).

Remember, terms in red are defined on pages 100-103.

Other Kinds of Health Insurance

What other kinds of health insurance or programs, besides Medigap, will pay for some of my health care costs not covered by Medicare?

There are several kinds of health coverage, besides Medigap, that pay for some of your health care costs not covered by Medicare. They include:

- Employee or retiree coverage from an employer or union: Call your benefit administrator to find out if you have or can get health care coverage based on your or your spouse's past or current employment. Since this kind of health insurance coverage is not a Medigap policy, the rules that apply to Medigap policies do not apply.

- COBRA Coverage (Consolidated Omnibus Budget Reconciliation Act of 1985): This law requires an employer to let you and your dependents stay covered under the employer's group health plan for a certain length of time after losing your job, having your work hours reduced, or after your spouse's death or a divorce. However, you may have to pay both your share and the employer's share of the premium. For more information on COBRA, see pages 70-72.

- The PACE Program (Programs of All-Inclusive Care for the Elderly): This program combines both inpatient and outpatient medical and long-term care services for eligible persons. To be eligible, you must be at least 55 years old, live in the service area of a PACE program, and be certified as eligible for nursing home care by the appropriate state agency. The goal of PACE is to keep you independent, and living in your community as long as possible, and to provide quality care at low cost. For more information on PACE, see page 76.

Caution: If you drop your employer or union group health coverage, you may not be able to get it back. For more information, call your benefit administrator.

Note: When you have retiree coverage from an employer or union, they have control over this insurance. They may change the benefits or premiums, and can also cancel the insurance if they choose.

Remember, terms in red are defined on pages 100-103.

Other Kinds of Health Insurance (continued)

- Federally Qualified Health Centers (FQHCs): These are special health centers, like a community health center, tribal health clinic, migrant health service, and health center for the homeless, that can give you routine health care at a lower cost. For more information on FQHCs, see page 77.

- Medicaid: This is a joint federal and state program that helps pay medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. If you cannot afford to pay your Medicare premiums and other health care costs, you may be able to get help from your state. For more information on Medicaid, see pages 78-79.

- Hospital Indemnity Insurance: This kind of insurance pays a certain cash amount for each day you are in the hospital up to a certain number of days. **It is not designed to fill gaps in your Medicare coverage**. For more information on hospital indemnity insurance, see page 80.

- Specified Disease Insurance: This kind of insurance pays benefits for only a single disease, such as cancer, or for a group of diseases. **It is not designed to fill gaps in your Medicare coverage.** For more information on specified disease insurance, see page 80.

- Long-Term Care Insurance: This kind of insurance policy may cover medical and non-medical care like care to help you with your daily needs, such as bathing, dressing, using the bathroom, and eating. Generally, Medicare does not pay for long-term care. This type of insurance may help fill some gaps in the coverage that you and/or your spouse may need in the future. For more information on long-term care insurance, see pages 80-82.

Remember, terms in red are defined on pages 100-103.

Summary of Medigap Basics

Medicare

Depending on where you live, you may have choices in how you get your health care:

- The Original Medicare Plan
- Medicare managed care plans
- Private Fee-for-Service plans - New in 2000

Medicare does not pay for all your health care. Medigap policies are designed to fill gaps in the Original Medicare Plan coverage.

Medigap Policies

- Up to 10 standardized Medigap plans may be available in your state (except in Massachusetts, Minnesota, and Wisconsin, see pages 94-96).
- Medigap policies only help pay health care costs if you have the Original Medicare Plan.
- Medigap policies (including Medicare SELECT) are sold by private insurance companies to help fill the gaps in the Original Medicare Plan.
- You choose the policy you want and pay a premium to the insurance company.

Using a Medigap Policy

- In most cases, your Medicare Carrier sends your claims to the Medigap insurance company.

Other Kinds of Health Insurance

There are other kinds of health care programs or insurance to help pay health care costs, like:

- Employer or Retiree Health Coverage
- COBRA
- PACE
- FQHC
- Medicaid
- Hospital Indemnity Insurance
- Specified Disease Insurance
- Long-Term Care Insurance

Note: These are not Medigap policies.

Whether you need a Medigap policy is a decision that only you can make. Depending on your health care needs and finances, you may want to continue your employee or retiree health coverage, or join a Medicare managed care plan, or a Private Fee-for-Service plan (available in 2000 in some areas). You may also want to think about your long-term care needs (see pages 80-82).

Part 2 - Beyond the Basics ▸

Part 2 goes beyond the basics. It gives more detailed information about what you learned in Part 1.

Buying a Medigap Policy .....Pages 23-61

Your Medigap Policy Choices .....Pages 23-24
What Medigap Policies Cover .....Pages 24-27
Shopping for a Medigap Policy .....Pages 27-35
Medigap Policies for People Age 65 and Older .....Pages 36-39
Medigap Policies for People Under Age 65 .....Pages 39-40
Medigap Protections.....Pages 41-61

Using a Medigap Policy .....Pages 62-66

How Your Bills Get Paid.....Page 62
Private Contracts.....Page 63-64
Switching Medigap Policies.....Pages 64-66

Other Kinds of Health Insurance .....Pages 67-82

Group Health Coverage .....Pages 67-69
More on Employee Coverage.....Pages 69-72
Who Pays First .....Pages 72-75
Other Health Insurance Options.....Pages 76-79
Other Private Health Insurance Options.....Page 80
Long-Term Care Insurance.....Pages 80-82

Remember, terms in red are defined on pages 100-103.

Buying a Medigap Policy

Your Medigap Policy Choices

If you live in Massachusetts, Minnesota, or Wisconsin, see pages 94-96.

What are my Medigap policy choices?

In all but three states (Massachusetts, Minnesota, and Wisconsin), you can buy any one of up to 10 standardized Medigap policies that are sold in your state. Plan A is the "basic" benefit package and is included in all the other plans. Insurance companies must give you the benefits offered under each policy.

Federal law lets states allow an insurer to add "new and innovative benefits" to the benefits in a standardized policy. Check with your insurance company to find out if these benefits are available.

What is Medicare SELECT?

Medicare SELECT is a type of Medigap insurance policy. If you buy a Medicare SELECT policy, you are buying one of the 10 standardized Medigap plans A through J. With a Medicare SELECT policy, you need to use specific hospitals and doctors to get full insurance benefits (except in an emergency). For this reason, Medicare SELECT policies generally have lower premiums.

For more information, call your State Health Insurance Assistance Program (see pages 88-89).

If you do not use a Medicare SELECT provider for non-emergency services, you will have to pay what Medicare doesn't pay. Medicare will pay its share of approved charges no matter what provider you choose. Medicare SELECT might not be offered in your state.

Remember, terms in red are defined on pages 100-103.

Is there any other important information I need to know?

There are many situations when your health coverage changes (like losing your Medicare managed care plan or employer coverage) that can affect what

Buying a Medigap Policy (continued)

Medigap policies you can buy and when. For more information on your rights to buy a Medigap policy in these situations, see pages 42-61.

What Medigap Policies Cover

What are the basic (core) benefits in all standardized Medigap plans?

- Coverage for the Part A coinsurance amount ($194 per day in 2000) for days 61-90 of a hospital stay in each Medicare benefit period.
- Coverage for the Part A coinsurance amount ($388 per day in 2000) for days 91-150 of a hospital stay while using Medicare's 60 lifetime reserve days (which you may only use once).
- After you use up all Medicare hospital benefits, coverage for 100% of the Medicare Part A eligible hospital expenses. You have this coverage for up to 365 more days of inpatient hospital care during your lifetime. After you use up your Medigap hospital benefits, you may have to pay the full cost of hospital expenses.
- Coverage under Medicare Part A and Part B for the reasonable cost of the first 3 pints of blood or equivalent quantities of packed red blood cells per calendar year unless this blood is replaced.
- Coverage for the coinsurance amount for Part B services (generally 20% of Medicare-approved amount) after you meet the $100 annual deductible.

For a higher Medigap premium, you can buy extra benefits (see pages 25-27).

Remember, terms in red are defined on pages 100-103.

Medigap Extra Benefits

Before you make any decisions about your health care coverage, think about your personal needs. Then, decide if the extra benefits offered are worth the extra premium costs.

Medicare Hospital Deductible
Plans B, C, D, E, F, G, H, I, and J

Medigap Plans B through J cover the Medicare hospital deductible, which is $776 in 2000. Keep in mind that the additional cost that you pay in premiums for this benefit is generally less than the cost of paying the hospital deductible. Each time you have to stay in the hospital you will have to pay the deductible if it's the beginning of a new benefit period.

Skilled Nursing Facility Coinsurance
Plans C, D, E, F, G, H, I, and J

Plans C through J cover the skilled nursing facility coinsurance, which is $97 a day in 2000. Medicare pays all of the covered costs for the first 20 days of care in a skilled nursing facility. If you are in a nursing facility for more than 20 days, Plans C through J will pay the $97 a day coinsurance for days 21 through 100.

Medicare Part B Annual Deductible
Plans C, F, and J

Plans C, F, and J cover the Medicare Part B deductible, which is $100 per year in 2000.

Foreign Travel Emergency
Plans C, D, E, F, G, H, I, and J

Plans C through J cover foreign travel emergencies. This benefit pays for emergency care outside the United States beginning the first 60 days of each trip. After you meet the $250 deductible, this benefit pays 80% of the cost of your care for up to $50,000 in your lifetime. If you travel, this benefit could save you money for emergency care.

Medigap Extra Benefits (continued)

At-Home Recovery
Plans D, G, I, and J

Plans D, G, I, and J cover the cost of at-home help with activities of daily living (like bathing and dressing) in addition to Medicare-covered home health visits. You can get this benefit if you are already getting Medicare-covered home health care services. It also covers home health care for up to 8 weeks after skilled care is no longer needed. However, it will not pay more than $40 each visit and $1,600 each year.

Medicare Part B Excess Charge
Plans F, G, I, and J

Plans F, G, I, and J cover Medicare Part B excess charges when your doctor charges more than Medicare will pay. These policies pay the difference between your doctor's charge and Medicare's approved amount. Plans F, I, and J pay all of the excess charges. Plan G pays 80% of the excess charges. Under federal law, doctors who don't accept "assignment" (take Medicare's approved amount as payment in full) may charge up to 15% more than the Medicare-approved amount (some states have even stricter limits). For example, if Medicare approves $100, your doctor can charge as much as $115. Plan F, I, or J would cover the $15 difference. Plan G would pay you $12 (80% of $15).

Assignment can save you money. Call 1-800-MEDICARE (1-800-633-4227) and ask for a free brochure.

Preventive Care
Plans E and J

Plans E and J cover preventive care, which is limited to $120 each year. The preventive care benefit helps pay for routine yearly check-ups, serum cholesterol screening, hearing test, diabetes screening, and thyroid function test.

Prescription Drugs
Plans H, I, and J

Plans H, I, and J offer some prescription drug coverage. This benefit has a $250 yearly deductible and pays 50% of drug costs that Medicare doesn't cover. It will only pay up to $1,250 a year under Plans H and I, and up to $3,000 a year under Plan J. You may think about this benefit if you have high prescription drug costs. Because it covers half your drug costs after the yearly deductible, to get the full benefit under Plans H and I, you should have at least $2,750 in drug costs in a year (you pay $1,250 plus $250; plan pays $1,250). To get the full benefit under Plan J, you should have at least

Remember, terms in red are defined on pages 100-103.

Medigap Extra Benefits (continued)

$6,250 in drug costs in a year (you pay $3000 plus $250; plan pays $3,000). Note: In some states, you may not be able to get policies with a prescription drug benefit unless you enroll during your open enrollment period.

Insurance companies may offer a high deductible option on Plans F and J. For more information on this option, see page 11.

More Information

For more information on Medigap policies, see the chart on page 10 or use a computer to look on the Internet at www.medicare.gov. Click on "Medigap Compare."

Shopping for a Medigap Policy

"When I was looking for my Medigap policy, I looked at what different policies cover, their prices, whether they covered prescription drugs...Once I found the company I wanted, I called the State Insurance Department to make sure it was a reliable company."

Janice, Washington, D.C.

Remember, terms in red are defined on pages 100-103.

What should I keep in mind as I shop for a Medigap policy?

As you shop for a Medigap policy, keep in mind that each company's benefits are alike, so they are competing on service, reliability, and price. Compare premiums and make sure that the insurance company is honest and reliable before buying. Insurer rating services look at the financial health of insurance companies. Different rating services use different rating scales. Be sure to find out how the rating service labels its highest ratings and the meaning of the ratings for the companies you are considering. You can get ratings from some insurer rating services for free at most public libraries. Your State Insurance Department can also give you information about the insurance companies (see pages 86-87). You can also use a computer to look on the Internet at www.medicare.gov. Click on "Medigap Compare."

Federal law lets states allow an insurer to add "new and innovative benefits" to the benefits in a standardized policy. Check with your insurance company to find out if these benefits are available.

Shopping for a Medigap Policy (continued)

What do I need to know about Medigap policy premiums?

There can be big differences in the premiums that insurance companies charge for exactly the same coverage. When you compare premiums, be sure you are comparing the same Medigap policies.

Insurance companies have three different ways of pricing policies based on your age:

- **No-age-rated (also called community-rated) policies**

  These policies charge everyone the same rate no matter how old they are.

Example:
Sally pays the same premium at each age.

Premium at Age 65	$60
Premium at Age 75	$60
Premium at Age 85	$60

Remember, all premiums may change and go up each year because of inflation and rising health care costs.

- **Issue-age-rated policies**

  The premium for these policies is based on your age when you first buy the policy, and the cost does not go up automatically as you get older.

Example:
Sally pays the same premium depending on how old she is when she buys the policy.

Buy Policy at Age 65

Premium at Age 65	$70
Premium at Age 75	$70
Premium at Age 85	$70

Shopping for a Medigap Policy (continued)

Buy Policy at Age 75

Premium at Age 65	--
Premium at Age 75	$95
Premium at Age 85	$95

Buy Policy at Age 85

Premium at Age 65	--
Premium at Age 75	--
Premium at Age 85	$130

- **Attained-age-rated policies**

  The premiums for these policies are based on your age each year. These policies are generally cheaper at age 65, but their costs go up automatically as you get older.

Remember, all premiums may change and go up each year because of inflation and rising health care costs.

Example:
Sally pays higher premiums as she gets older.

Premium at Age 65	$50
Premium at Age 75	$85
Premium at Age 85	$120

Caution: In general, attained-age-rated policies cost less when you are 65 than issue-age-rated or no-age-rated policies. However, between the ages of 70 and 75, attained-age-rated policies usually cost more than other types of policies.

Shopping for a Medigap Policy (continued)

What other factors may affect my premium when I buy a Medigap policy?

Other factors that may affect your premium when you buy a Medigap policy are:

- Whether you are male or female. Some companies offer discounts for females.
- Whether you smoke or not. Some companies offer discounts for non-smokers.
- Whether you are married or not. Some companies offer discounts for married couples.

What is underwriting? Can it affect the cost of my Medigap policy?

Medical underwriting is the process that a company uses to review your health and decide whether to accept your application for insurance. You usually must answer medical questions on an application. You need to fill out this application carefully (see page 34). Some companies may want to review your medical records before they sell you a policy. The company may use this information to add a waiting period for pre-existing conditions if your state law allows. The company may also use this information to decide how much to charge you for a Medigap policy.

The company may not deny you coverage or charge you more for a policy if you are in your Medigap open enrollment period or when you have the right to buy a Medigap policy.

Insurance companies may "medically underwrite" any Medigap policy at times other than open enrollment or when you have a right to buy a Medigap policy (see pages 41-61).

Remember, terms in red are defined on pages 100-103.

Shopping for a Medigap Policy (continued)

Whether you need a Medigap policy is a decision that only you can make. Depending on your health care needs and finances, you may want to continue your employee or retiree health coverage, or join a Medicare managed care plan or a Private Fee-for-Service plan (available in 2000 in some areas). You may also want to think about your long-term care needs (see page 80).

Shopping Tips

If you decide to buy a Medigap policy, shop carefully. Look for a policy that you can afford and that gives you the coverage you need most. Read the following tips to help you shop for a Medigap policy.

☑ Review the plans

The benefits in each of the standardized Medigap policies are the same no matter which insurance company sells it. Review the plans and choose the benefits that you need most.

☑ Shop carefully before you buy

Although each of the standardized Medigap policies is the same no matter which insurance company sells it, the costs may be very different. Companies use different ways to price Medigap policies. Companies also differ in customer service. Call different insurance companies and compare cost and service before you buy.

☑ Don't buy more than one Medigap policy at a time

It is illegal for an insurance company to sell you a second Medigap policy unless you tell them in writing that you are going to cancel the first Medigap policy when the second Medigap policy goes into effect. Call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) to report anyone who tries to sell you a Medigap policy when you already have one.

Shopping for a Medigap Policy (continued)

☑ Check for pre-existing condition exclusions

Before you buy a Medigap policy, you should find out whether it has a waiting period before it fully covers your pre-existing conditions. If you have a health problem that was diagnosed or treated during the 6 months immediately before the Medigap policy starts, the policy might not cover your costs right away for care related to that health problem. Medigap policies must cover pre-existing conditions after the policy has been in effect for 6 months. Some insurance companies may have shorter waiting periods before covering a pre-existing condition. Other insurance companies may not have any waiting period. If you buy a policy during your Medigap open enrollment period, the insurance company must shorten the waiting period for pre-existing conditions by the amount of previous health coverage you have. This is called creditable coverage (see page 38).

☑ Be careful of switching from one Medigap policy to another

You should only switch policies to get different benefits, better service, or a better price. However, do not keep a policy that does not meet your needs because you have had it for a long time. If you decide to buy a new Medigap policy, the company must count the time you had the same benefits under the first policy towards the pre-existing condition waiting period. However, you may have a waiting period for pre-existing conditions for new benefits that you did not have under your first policy. You must also sign a statement that you plan to cancel the first policy. Do not cancel the first policy until you are sure that you want to keep the new policy. You have 30 days to decide if you want to keep the new policy. This is called your free look period.

☑ Make sure you get your policy within 30 days

You should get your policy within 30 days. If you do not, call the company and ask them to put in writing why the policy was delayed. If 60 days go by without an answer, call your State Insurance Department (see pages 86-87).

Shopping for a Medigap Policy (continued)

☑ **Watch out for illegal marketing practices**

It is illegal for an insurance company or agent to pressure you into buying a Medigap policy, or lie to you or mislead you to get you to switch from one company or policy to another. False advertising is also illegal. Another type of illegal advertising involves mailing cards to people who may want to buy insurance. If you fill out and return the card enclosed in the mailing, the card may be sold to an insurance agent who will try to sell you a policy.

☑ **Neither the state nor federal government sells or services Medigap policies**

State Insurance Departments approve Medigap policies sold by private insurance companies. This means that the company and Medigap policy meet requirements of state law. Do not believe statements that Medigap insurance is a government-sponsored program (like the Original Medicare Plan). It is illegal for anyone to tell you that they are from the government and try to sell you a Medigap policy. If this happens to you, report that person to your State Insurance Department (see pages 86-87). It is also illegal for a company or agent to claim that a Medigap policy has been approved for sale in any state in which it has not been.

☑ **Find out if the insurance company is licensed**

An insurance company must meet certain standards in order to sell policies in your state. You should check with your State Insurance Department to make sure that the insurance company you are doing business with is licensed in your state. This is for your protection. Insurance agents must also be licensed by your state and the state may require them to carry proof that they are licensed. The proof will show their name and the name of the companies they represent. Do not buy a policy from any insurance agent that cannot prove that he or she is licensed. **A business card is not a license**.

Shopping for a Medigap Policy (continued)

☑ Start looking early so you won't be rushed

Do not be pressured into buying a Medigap policy. Good sales people will not rush you. Keep in mind, that if you are within your 6-month Medigap open enrollment period (see page 36) or in a situation where you have a guaranteed right to buy a Medigap policy, there are time limits you must follow (see pages 41-61). Buying the Medigap policy of your choice may be harder after the Medigap open enrollment or special protection period ends. This will be especially true if you have a pre-existing health condition. If you are not sure whether a Medigap policy is what you need, ask the salesperson to explain it to you with a friend or family member present.

☑ Keep agents' and/or companies' names, addresses, and telephone numbers

Write down the agents' and/or companies' names, addresses, and telephone numbers or ask for a business card with this information.

☑ If you decide to buy, fill out the application carefully

Do not believe an insurance agent who says your medical history on an application is not important. Some companies ask for detailed medical information. You must answer the medical questions even if you are applying during your Medigap open enrollment period (see page 36) or you are in a situation where you have the right to buy a Medigap policy (see pages 41-61). During these two times, the company cannot use your answers to turn you down or use this information to decide how much to charge you for a Medigap policy. However, if you leave out any of the medical information they ask for, the company could refuse to cover you for a period of time for any medical condition you did not report. The company also could deny a claim or cancel your Medigap policy if you send in a bill for care of a health problem you did not report.

Shopping for a Medigap Policy (continued)

☑ Beware of non-standardized plans

It is illegal for anyone to sell you a policy and call it a Medigap policy if it does not match the standardized Medigap policies sold in your state. A doctor may offer you a "retainer agreement" that says he/she can provide certain non-Medicare-covered services and not charge you the Medicare coinsurance and deductible amounts. This type of agreement may be illegal. If a doctor refuses to see you as a Medicare patient unless you pay him or her a yearly fee and sign a "retainer agreement," you should call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired).

☑ Look for an outline of coverage

You must be given a clearly worded summary of a Medigap policy. **Read it carefully**.

☑ Do not pay cash

Pay by check, money order, or bank draft payable to the insurance company, not the agent or anyone else. Get a receipt with the insurance company's name, address, and telephone number for your records.

Medigap Policies for People Age 65 and Older

When do most people buy a Medigap policy?

Most people buy a Medigap policy during their Medigap open enrollment period. Your Medigap open enrollment period lasts for six months after the first day of the month in which you are both age 65 or older **and** enrolled in Medicare Part B. Once the six month Medigap open enrollment period starts, it cannot be changed. During this time, you have the right to buy the Medigap policy of your choice and the insurance company cannot deny you insurance coverage, place conditions on a policy (like making you wait for coverage to start), or change the price of a policy because of past or present health problems. If you buy a policy during your Medigap open enrollment period, the insurance company must shorten the waiting period for pre-existing conditions by the amount of previous health coverage you have. This is called creditable coverage (see page 38).

Example (Open Enrollment) ▸

Mr. Smith is 68 and has heart disease. He has just enrolled in Medicare Part B and his coverage starts on March 1, 2000. Mr. Smith has until September 1, 2000 to buy his Medigap policy without his heart disease affecting the cost or type of policy he can choose. After September 1, 2000, Mr. Smith will not have this guarantee.

How can I tell if I am in my Medigap open enrollment period?

Your Medicare card shows the dates that your Part A and/or Part B coverage started. If you are age 65 or older, you can figure out whether you are in your Medigap open enrollment period by adding 6 months to the date that your Part B coverage starts. If that date is in the future, you are still in your Medigap open enrollment period. If that date is in the past, you have missed your Medigap open enrollment period.

Remember, terms in red are defined on pages 100-103.

Medigap Policies for People Age 65 and Older (continued)

"My wife had an insurance policy through her employer and I was on her policy. When she retired, she changed to my policy. Then, when I retired, we decided to get Medicare Part B and buy a Medigap policy."

Larry,
Boston, Massachusetts

Example ▸

Remember, terms in red are defined on pages 100-103.

Should I enroll in Medicare Part B and start my Medigap open enrollment period if I am age 65 or over and still working?

If you enroll in Medicare Part B to supplement your employer or union coverage, you will start your Medigap open enrollment period when it may be of little use to you. You may want to wait to enroll in Medicare Part B if you have health coverage through an employer or union based on your or your spouse's **current or active** employment (see page 5 "Special Enrollment Period"). Carefully consider your options. **Once you are age 65 or older and enrolled in Part B, the 6-month Medigap open enrollment period starts and cannot be changed.**

Mrs. Poole just turned 65. She is still working and has health coverage through her employer. She decides to enroll in Medicare Part B. Her coverage will begin on May 1, 2000. Mrs. Poole decides she doesn't need to buy a Medigap policy because her employer group health plan covers the same benefits as a Medigap policy. However, once she is enrolled in Part B, her Medigap 6-month open enrollment period will start. Therefore, Mrs. Poole will have until November 1, 2000 to buy the Medigap policy of her choice without conditions or price changes even though she doesn't need it.

Should I wait to get Medicare Part B and start my Medigap open enrollment period if I am in good health?

If you are over age 65 and still working, you may want to wait to take Part B until you can make the best use of your Medigap insurance open enrollment period. However, the cost of Part B may go up 10% for each 12-month period that you could have had Part B but did not take it, except in special cases (see page 5, "Special Enrollment Period"). An insurance

Medigap Policies for People Age 65 and Older (continued)

company would probably accept your application, use medical underwriting to decide if they will sell you a policy, and charge you a reasonable premium. However, this is not guaranteed. Remember, your health could change at any time!

Will my pre-existing conditions be covered if I buy a Medigap policy?

If you buy a Medigap policy during your Medigap open enrollment period, the insurance company can refuse to cover care for pre-existing conditions for up to 6 months. This only applies to conditions that were diagnosed or treated during the 6 months immediately before the start of your Medigap policy. This 6-month period is called the pre-existing condition waiting period. However, they cannot refuse to cover pre-existing conditions if you have at least 6 months of creditable coverage. Any new health problem would be covered immediately, regardless of whether you had creditable coverage.

What is creditable coverage?

Creditable coverage is any previous health coverage you had under:

- a group health plan (like an employer plan);
- a health insurance policy;
- Medicare Part A or Part B;
- Medicaid;
- a medical program of the Indian Health Service or tribal organization;
- a State health benefits risk pool;
- TRICARE (the health care program for military dependents and retirees);
- the Federal Employees Health Benefit Plan;
- a public health plan; or
- a health plan under the Peace Corps Act.

Note: Whether you can use creditable coverage depends on whether you had any "breaks in coverage." If there was any time that you had **no** health coverage of any kind, and during that time you were without coverage for more than 63 days, you can only count creditable coverage that you had **after** that break in coverage.

Remember, terms in red are defined on pages 100-103.

Medigap Policies for People Age 65 and Older (continued)

Example (Creditable Coverage) ▸

Mrs. Johnson is 68 and has heart disease. She has had Medicare Part B since November 1, 2000. Before this date, she had no health insurance. On March 1, 2001, Mrs. Johnson buys a Medigap policy. Her insurance company may refuse to cover her pre-existing heart disease condition for 6 months (the pre-existing condition waiting period). However, Mrs. Johnson can use her 4 months of Medicare Part B coverage to shorten this 6 month pre-existing condition waiting period. This waiting period will now be 2 months instead of 6 months. During these 2 months, after Medicare pays its share, Mrs. Johnson will have to pay the rest of the costs for the care of her heart disease.

Medigap Policies for People Under Age 65

Is there a Medigap open enrollment period for people under age 65 who first get Medicare because of a disability or End-Stage Renal Disease (ESRD)?

Yes, but only when you turn age 65.

You may have Medicare Part B benefits before age 65 due to a disability or ESRD (permanent kidney failure treated with dialysis or a kidney transplant). In this case, you may not be able to buy a Medigap policy right away, but you will have the right to choose and buy any Medigap policy when you turn age 65. It does not matter that you had Medicare Part B before you turned age 65.

For 6 months after you turn age 65 **and** are enrolled in Medicare Part B:

- You can buy any Medigap policy (including those policies that pay for prescription drugs), and
- Insurance companies cannot refuse to sell you a Medigap policy due to a disability or other health problem.

Medigap Policies for People Under Age 65 (continued)

When you buy a policy during your Medigap open enrollment period, the insurance company must shorten the waiting period for pre-existing conditions by the amount of creditable coverage you have. If you had Medicare for more than 6 months, you will not have a pre-existing condition waiting period because Medicare counts as creditable coverage.

Several states require Medigap insurance companies to offer a limited Medigap open enrollment period for people with Medicare Part B who are under age 65. At the time of this printing, the following states require insurance companies to offer a Medigap open enrollment period to people with Medicare under age 65:

- Connecticut
- Delaware
- Kansas
- Louisiana
- Maine
- Maryland
- Massachusetts
- Michigan
- Minnesota
- Missouri
- New Hampshire
- New Jersey
- New York
- Oklahoma
- Oregon
- Pennsylvania
- Texas
- Wisconsin

Also, some insurance companies will sell Medigap policies to people with Medicare under age 65. However, these policies may cost you more. Remember, if you live in a state that has a Medigap open enrollment period for people under age 65, you will still get another Medigap open enrollment period when you turn age 65.

Also, if you join a Medicare health plan and your coverage ends, you may have the right to buy a Medigap policy (see Situations #1 and #2 on page 42).

If you have questions, you should call your State Health Insurance Assistance Program (see pages 88-89).

Remember, terms in red are defined on pages 100-103.

Introduction to Medigap Protections

What are Medigap protections?

Medigap protections are special rights you have to buy a Medigap policy in addition to your Medigap open enrollment period. These are also called "guaranteed issue" rights because insurance companies are required by law to issue you a policy. These protections are important because if you do not buy a Medigap policy during your Medigap open enrollment period, an insurance company might be able to refuse to sell you a policy, or you may be charged more for the policy. In addition, if you drop your Medigap policy, you may not be able to get it back unless you have this protection.

The Medigap protections in this section are from federal law. Some states provide more Medigap protections than federal law. At the time this Guide was printed, these states reported that they offer more Medigap protections than federal law requires:

- Arkansas
- Delaware
- Florida
- Iowa
- Illinois
- Indiana
- Kansas
- Maine
- Massachusetts
- North Carolina
- New Hampshire
- New Mexico
- Nevada
- New York
- South Dakota
- Texas
- Vermont
- Wisconsin
- West Virginia
- Wyoming

Call your State Insurance Department (see pages 86-87) or State Health Insurance Assistance Program (see pages 88-89) to find out if your state offers more Medigap protections than federal law.

Medigap Protections

When do I have a right to Medigap protections?

There are a few types of situations involving health coverage changes where you may have a guaranteed issue right to buy a Medigap policy even when you are not in your Medigap open enrollment period. For example:

1. Your Medicare managed care plan or Private Fee-for-Service plan coverage ends because the plan is leaving the Medicare program or stops giving care in your area (see Situation #1 on pages 43-47), or

2. Your health coverage (like a Medicare managed care plan or Private Fee-for-Service plan, employer group health plan that supplemented or paid some of the costs not paid for by Medicare, Medicare SELECT policy or Program of All-Inclusive Care for the Elderly (PACE), or Medicare managed care demonstration project) ends through no fault of your own including your moving outside of the plan's service area (see Situation #2 on pages 47-50), or

3. You dropped your Medigap policy to join a Medicare managed care plan or Private Fee-for-Service plan, or buy a Medicare SELECT policy for the first time, and then leave the plan or policy within one year after joining (see Situation #3 on pages 51-54), or

4. You joined a Medicare health plan (like a Medicare managed care plan with a Medicare + Choice contract or Private Fee-for-Service plan) when you first became eligible for Medicare at age 65 and within one year of joining, you decided to leave the health plan (see Situation #4 on pages 55-57).

Each situation will be discussed in detail on the following pages.

If you live in Massachusetts, Minnesota, or Wisconsin, you have the right to buy a Medigap policy that is similar to the standardized policies you have a right to buy in the other states. Call your State Insurance Department (see pages 86-87).

Medigap Protections (continued)

Situation #1 ▸

Can I buy a Medigap policy if my Medicare managed care plan or Private Fee-for-Service plan leaves the Medicare program or stops giving care in my area?

If your Medicare managed care plan or Private Fee-for-Service plan leaves the Medicare program or stops giving care in your area, you have the right to buy Medigap plans A, B, C, or F that are sold in your state.

In some cases, you have the right to return to your old Medigap policy (see Situation #3 on pages 51-54) or to buy any of the 10 standardized Medigap policies sold in your state (see Situation #4 on pages 55-57).

If you get a letter telling you that your Medicare managed care plan or Private Fee-for-Service plan is leaving the Medicare program or will no longer give care in your area, you may have three choices:

1. **Stay in your plan until the date your coverage ends.** You have 63 calendar days after your health coverage ends to apply for a Medigap policy.

2. **Switch to another Medicare managed care plan in your area.** In some cases, you may have to wait until the new plan is accepting new members to join.

3. **Leave your plan (disenroll) as soon as you get your letter.** You have 63 calendar days from the date on the letter from your Medicare managed care plan or Private Fee-for-Service plan telling you that the plan will no longer be giving care in your area, to apply for a Medigap policy.

Choice #3 only applies to Private Fee-for-Service plans or Medicare managed care plans with a "Medicare + Choice" contract (not a "cost contract").

Medigap Protections (continued)

Situation #1 (continued) ▸

Call your managed care plan to find out what kind of contract they have so you will know if you can leave the plan as soon as you get your letter without losing your Medigap protections.

You have the right to buy Medigap plans A, B, C, or F that are sold in your state. If you decide to leave your plan before your coverage ends, you must turn in a **written** request to your plan telling them you want to leave (disenroll). Your coverage will end on the last day of the month in which your plan gets your written request to leave (see Example #1a).

Example #1a ▸

In October 2000, Mrs. Walton receives a letter from her Medicare managed care plan (with a Medicare + Choice contract) telling her that the plan will be leaving the Medicare program on December 31, 2000. The letter is dated October 1, 2000. She decides to get health care coverage from the Original Medicare Plan. She turns in her written request to leave her plan on October 12, 2000. Her coverage will end October 31, 2000. Mrs. Walton has the right to buy Medigap plans A, B, C, or F that are sold in her state as long as she applies by December 2, 2000 (63 calendar days from the date on the plan's letter to her).

Medigap Protections (continued)

Situation #1 (continued) ▸

As long as you apply for your new Medigap policy no later than 63 calendar days from the date on the letter from your plan or no later than 63 calendar days after your health coverage ends (see Example #1b), the insurance company:

- Cannot deny you insurance coverage or place conditions on the policy (such as making you wait for coverage to start);
- Must cover you for all pre-existing conditions;
- Cannot charge you more for a policy because of past or present health problems.

Example #1b ▸

In October 2000, Mrs. Walton receives a letter from her Medicare managed care plan telling her that it will be leaving the Medicare program on December 31, 2000. The letter is dated October 1, 2000. She decides to stay in her plan until her coverage ends on December 31, 2000. She will automatically be enrolled in the Original Medicare Plan starting January 1, 2001. Mrs. Walton has the right to buy Medigap plans A, B, C, or F that are sold in her state as long as she applies by March 4, 2001 (63 calendar days after her health coverage ends).

Important: When your health coverage ends, your health plan will send you a letter telling you that your coverage is ending. Keep a copy of the letter (make sure that your name is on the letter) and the postmarked envelope to prove that you lost coverage from your health plan. You should also keep a dated copy of your Medigap policy application, and any insurance company denial letters that are mailed to you to prove that you have been denied your Medigap rights if this happens.

Medigap Protections (continued)

Situation #1 (continued) ▸

Does this protection cover me if I am under age 65 and have Medicare because of a disability or End-Stage Renal Disease (ESRD)?

There is no federal law that requires insurance companies to have general Medigap open enrollment periods for people under age 65. However, if any insurance company in your state sells Medigap plans A, B, C, or F to people under age 65, either voluntarily or because it is required by state law, they must sell you a policy if you are in situation #1, #2, or #3 listed on page 42. For more information, call your State Health Insurance Assistance Program (see pages 88-89).

Summary of your Medigap Protections if your Medicare managed care plan or Private Fee-for-Service plan leaves the Medicare program or will no longer be giving care in your area:

- You may have three choices about what to do, and when to do it (see page 43);
- You have the right to buy Medigap plans A, B, C, or F that are sold in your state as long as you apply no later than 63 calendar days from the date on the letter from your plan or no later than 63 calendar days after your health coverage ends;
- The insurance company cannot deny you insurance coverage or place conditions on the policy (such as making you wait for coverage to start);
- The insurance company must cover you for all pre-existing conditions;
- The insurance company cannot charge you more for a policy because of past or present health problems;

Remember, terms in red are defined on pages 100-103.

Medigap Protections (continued)

Situation #1 (continued) ▸

- If you are under age 65 and have Medicare because of a disability or ESRD, you must be allowed to buy Medigap plans A, B, C, or F that are otherwise sold in your state to people under age 65 with Medicare.

Remember, if you wish to leave the plan as soon as you get your letter without losing your Medigap protections, you should first call your managed care plan to make sure it has a "Medicare + Choice" contract rather than a "cost contract."

Another Option

Even if you do not meet the conditions for Medigap protections, your insurance company may still allow you to buy any Medigap policy, especially if you are in good health. For more information, call your State Health Insurance Assistance Program (see pages 88-89).

Situation # 2 ▸

Can I buy a Medigap policy if my health coverage ends other than in the case where my Medicare managed care plan leaves the Medicare program?

If your health coverage (like a Medicare managed care plan, Private Fee-for-Service plan, employer group health plan that supplemented or paid some of the costs not paid for by Medicare, Medicare SELECT policy, or Programs of All-Inclusive Care for the Elderly (PACE), or Medicare managed care demonstration project) ends, in certain situations you have the right to buy Medigap plans A, B, C, or F that are sold in your state. You must apply no later than 63 calendar days after your health coverage ends.

For more information on PACE, see page 76.

The insurance company must sell you one of these Medigap plans if:

- You move outside of the plan's service area (the

Medigap Protections (continued)

Situation # 2 ▸ (continued)

area where the plan accepts members and where you get services from the plan); or

- You leave the health plan because it failed to meet its contract obligations to you (for example, the marketing material was misleading or quality standards were not met); or
- You were in an employer group health plan that supplemented or paid some of the costs not paid for by Medicare, and the plan ends your coverage; or
- Your insurance company ends your Medicare SELECT policy and you're not at fault (for example, the company goes bankrupt); or
- Your PACE program stops participating in Medicare or stops giving care in your area.

As long as you apply for your new Medigap policy no later than 63 calendar days after your health coverage ends, the insurance company:

- Cannot deny you insurance coverage or place conditions on the policy (like making you wait for coverage to start);
- Must cover you for all pre-existing conditions;
- Cannot charge you more for a policy because of past or present health problems.

You should not wait until your health coverage has almost ended before you apply for a Medigap policy. You can apply for a Medigap policy early (while you are still in your health plan) and choose to start your Medigap coverage the day after your health plan coverage ends. This will prevent gaps in your health coverage (see Example #2 on page 49).

Caution: In most cases in Situation #2, you must stay in your health plan until the date your coverage ends. If you leave the plan before that date, you may lose your right to buy Medigap plans A, B, C, or F that are sold in your state.

Remember, terms in red are defined on pages 100-103.

Medigap Protections (continued)

Situation # 2 (continued) ▸

Example #2 ▸

Mrs. Jones was covered under an employer group health plan that paid some of the costs not paid for by Medicare. She got a letter in the mail telling her that her health plan coverage was ending on April 5, 2000. Mrs. Jones wanted to buy a Medigap policy that would help pay her health care costs not covered by Medicare. Because her health care coverage was ending, Mrs. Jones had the right to buy Medigap plans A, B, C, or F that were sold in her state as long as she applied by June 7, 2000 (63 calendar days after her health coverage ended). She had to stay in her employer group health plan until the date her coverage ended, or she would lose her right to buy one of these Medigap plans. Mrs. Jones applied for a Medigap policy on March 16, 2000 and chose to start her Medigap coverage on April 6, 2000, the day after her health coverage ended. This prevented gaps in her health coverage.

Important: When your health coverage ends, your health plan will send you a letter telling you that your coverage is ending. Keep a copy of the letter (make sure that your name is on the letter) and the postmarked envelope to prove that you lost coverage from your health plan. You should also keep a dated copy of your Medigap policy application, and any insurance company denial letters that are mailed to you to prove that you have been denied your Medigap rights if this happens.

Does this protection cover me if I am under age 65 and have Medicare because of a disability or End-Stage Renal Disease (ESRD)?

There is no federal law that requires insurance companies to have general Medigap open enrollment periods for people under age 65. However, if any insurance company in your state sells Medigap plans

Medigap Protections (continued)

Situation # 2 (continued) ▶

A, B, C, or F to people under age 65, either voluntarily or because it is required by state law, they must sell you a policy if you are in situations #1, #2, or #3 listed on page 42. For more information, call your State Health Insurance Assistance Program (see pages 88-89).

Summary of your Medigap Protections if your health coverage ends (except in the case where your Medicare managed care plan or Private Fee-for-Service plan leaves the Medicare program, see page 43):

- You have the right to buy Medigap plans A, B, C, or F that are sold in your state as long as you apply no later than 63 calendar days after your health coverage ends;
- The insurance company cannot deny you insurance coverage or place conditions on the policy (like making you wait for coverage to start);
- The insurance company must cover you for all pre-existing conditions;
- The insurance company cannot charge you more for a policy because of past or present health problems;
- If you are under age 65 and have Medicare because of a disability or ESRD, you must be allowed to buy Medigap plans A, B, C, or F that are otherwise sold in your state to people under age 65 with Medicare.

Another Option

Even if you do not meet these conditions for Medigap protections, your insurance company may

Medigap Protections (continued)

still allow you to buy any Medigap policy, especially if you are in good health. For more information, call your State Health Insurance Assistance Program (see pages 88-89).

Situation # 3 ▸

If I drop my Medigap policy to join a Medicare managed care plan or Private Fee-for-Service plan, or buy a Medicare SELECT policy, and then leave the plan or policy, will I be able to get my Medigap policy back?

Maybe. If you dropped your Medigap policy to join a Medicare health plan (like a Medicare managed care plan or a Private Fee-for-Service plan) or buy a Medicare SELECT policy, and then leave the plan or policy, under certain conditions, you may be able to return to the Medigap policy you had before (if it is still available).

You have this protection, if:

- This is the first time that you have ever been enrolled in a Medicare health plan or Medicare SELECT policy; and
- You leave the Medicare health plan or Medicare SELECT policy within one year after joining.

You must apply for your former Medigap policy no later than 63 calendar days after your Medicare health plan coverage ends (see Example #3 on page 53). If your former Medigap policy is no longer available, see "What can I do if the Medigap policy I had is no longer available?" on page 52.

Remember, you should not wait until your Medicare health plan coverage has almost ended before you apply for a Medigap policy. You can apply for a Medigap policy early (while you are still in your Medicare health plan) and choose to start your Medigap coverage the day after your health plan

Medigap Protections (continued)

Situation # 3 (continued) ▸

coverage ends. This will prevent gaps in your health coverage (see Example #3 on page 53.)

Important: If you bought a Medigap policy before 1990, your policy is not a standardized Medigap policy. It may have benefits that are different from the 10 standardized Medigap plans. Therefore, if you dropped it, you would not be able to get it back because that policy is no longer being sold.

What can I do if the Medigap policy I had is no longer available?

If your former Medigap policy is no longer available, you have the right to buy Medigap plans A, B, C, or F from any insurance company which sells these plans in your state. You must apply no later than 63 calendar days after your Medicare health plan coverage ends. As long as you apply for your new Medigap policy no later than 63 calendar days after your health coverage ends, the insurance company:

- Cannot deny you insurance coverage or place conditions on the policy (like making you wait for coverage to start);
- Must cover you for all pre-existing conditions; and
- Cannot charge you more for a policy because of past or present health problems.

Important information about Medicare SELECT policies.

You may also have this same protection if you dropped a Medicare SELECT policy to join a Medicare health plan (like a Medicare managed care plan). This is because a Medicare SELECT policy is a type of Medigap policy.

Medigap Protections (continued)

Situation # 3 (continued) ▸

If you currently have a Medicare SELECT policy, you also have the right to switch, at any time, to a regular Medigap policy that is sold by the same company (if any are available). The Medigap policy you switch to must have equal or less coverage than the Medicare SELECT policy you currently have.

Example #3 ▸

Mr. Perkins joined a Medicare managed care plan on December 1, 2000. He had never been in a Medicare managed care plan before. Before that, Mr. Perkins was in the Original Medicare Plan and had a Plan J Medigap policy. Six months later, Mr. Perkins decided to leave the managed care plan and return to the Original Medicare Plan. He put in his request in writing to leave his managed care plan on June 5, 2001. His managed care plan coverage ended on June 30, 2001. Because this was the first time he had ever been in a Medicare managed care plan, he had the option of returning to his Plan J Medigap policy as long as he applied for it by September 1, 2001 (63 calendar days after his health coverage ended). Mr. Perkins found out that his Medigap insurance company still sold Medigap policy Plan J. He applied for it on June 10, 2001, and chose to start his Medigap coverage on July 1, 2001, the day after his Medicare health plan coverage ended. This prevented gaps in his health coverage.

Remember, terms in red are defined on pages 100-103.

Medigap Protections (continued)

Situation # 3 (continued) ▸

Summary of your Medigap protections if you dropped your Medigap policy to join a Medicare health plan (like a Medicare managed care plan or Private Fee-for-Service plan), or buy a Medicare SELECT policy for the first time, then leave the plan or policy within one year after joining:

- You have the right to return to your former Medigap policy (if it is still available from the same insurance company). You must apply no later than 63 calendar days after your Medicare health plan coverage ends;
- If your former policy is not available, you have the right to buy Medigap plans A, B, C, or F that are sold in your state as long as you apply no later than 63 calendar days after your Medicare health plan coverage ends;
- The insurance company cannot deny you insurance coverage or place conditions on the policy (like making you wait for coverage to start);
- The insurance company must cover you for all pre-existing conditions;
- The insurance company cannot charge you more for a policy because of past or present health problems.

Another Option

Even if you do not meet these conditions for Medigap protections, your insurance company may still allow you to buy any Medigap policy, especially if you are in good health. For more information, call your State Health Insurance Assistance Program (see pages 88-89).

Medigap Protections (continued)

Situation # 4 ▸

Is there any other time when I have the right to buy any of the 10 standardized Medigap policies, other than during my Medigap open enrollment period?

Yes. You have the right to buy **any** Medigap policy sold in your state if:

- You joined a Medicare health plan (like a Medicare managed care plan with a Medicare + Choice contract or a Private Fee-for-Service plan), when you first became eligible for Medicare at age 65*, **and**
- You leave the plan within one year after joining.

This only applies to Private Fee-for-Service plans or Medicare managed care plans with a Medicare + Choice contract. Call your managed care plan to find out if they have a Medicare + Choice contract.

You must apply for the Medigap policy no later than 63 calendar days after your Medicare health plan coverage ends. As long as you apply for your new Medigap policy no later than 63 calendar days after your health coverage ends, the insurance company:

- Cannot deny you insurance coverage or place conditions on the policy (like making you wait for coverage to start);
- Must cover you for all pre-existing conditions; and
- Cannot charge you more for a policy because of past or present health problems.

You should not wait until your Medicare health plan coverage has almost ended before you apply for a Medigap policy. You can apply for a Medigap policy early (while you are still in your Medicare health plan) and choose to start your Medigap coverage the day after your Medicare health plan coverage ends. This will prevent gaps in your health coverage (see Example #4 on page 56).

*You are eligible for Medicare on the first day of the month in which you turn age 65. If your birthday is on the first day of the month, your Medicare coverage starts on the first day of the month before your birthday.

Medigap Protections (continued)

Situation # 4 (continued) ▸

Note: If you are still in your 6-month Medigap open enrollment period after you leave your Medicare health plan, you may have more than 63 calendar days to buy a Medigap policy. For more information, call your State Health Insurance Assistance Program (see pages 88-89).

Example #4 ▸

Mrs. Miner joined a Medicare managed care plan on February 1, 2000, the first day of the month in which she turned 65. Six months later, she decided to leave her plan. She turned in her written request to leave her plan on August 3, 2000. Her managed care plan coverage ended on August 30, 2000. Since she did not choose to join another managed care plan, she was automatically enrolled in the Original Medicare Plan. Mrs. Miner had the right to buy any Medigap policy, as long as she applied by November 2, 2000 (63 calendar days after her health coverage ended). Mrs. Miner applied for her Medigap policy on August 25, 2000, and chose to start her Medigap coverage on September 1, 2000, the day after her Medicare health plan coverage ended. This prevented gaps in her health coverage.

Remember, terms in red are defined on pages 100-103.

Medigap Protections (continued)

Situation # 4 (continued) ▶

Summary of Medigap protections when you joined a Medicare health plan (like a Medicare managed care plan with a Medicare + Choice contract or a Private Fee-for-Service plan) when you first became eligible for Medicare at age 65, and you leave the plan within one year after joining:

- You have the right to buy **any** Medigap policy sold in your state as long as you apply no later than 63 calendar days after your Medicare health plan coverage ends;
- The insurance company cannot deny you insurance coverage or place conditions on the policy (like making you wait for coverage to start);
- The insurance company must cover you for all pre-existing conditions;
- The insurance company cannot charge you more for a policy because of past or present health problems.

Another Option

Even if you do not meet these conditions for Medigap protections, your insurance company may still allow you to buy any Medigap policy, especially if you are in good health. For more information, call your State Health Insurance Assistance Program (see pages 88-89).

General Medigap Protection Information

If you think any of the previous situations apply to you, you may have the right to buy a Medigap policy. Call your State Health Insurance Assistance Program (see pages 88-89) to make sure that you qualify for these Medigap protections. They can also help you find the Medigap policy that is right for you.

Important: When your health coverage ends (see Situation #1 on page 43 and Situation #2 on page 47), your health plan will send you a letter telling you that your coverage is ending. Keep a copy of the letter (make sure that your name is on the letter) and the postmarked envelope to prove that you lost coverage from your health plan. You should also keep a dated copy of your Medigap policy application, and any insurance company denial letters that are mailed to you to prove that you have been denied your Medigap rights if this happens.

If you are denied Medigap coverage, call your State Insurance Department (see pages 86-87).

Remember, to get these protections, you must apply no later than 63 calendar days after your health coverage ends.

Summary of Medigap Protections Chart

The following chart is a summary of the situations, explained on the previous pages, that may give you the right to buy a Medigap policy when your health coverage changes, and the protections that apply for each situation. In order to get these Medigap protections, you must meet certain conditions. See the following chart for more details. If you live in Massachusetts, Minnesota, or Wisconsin see page 42 for your protections.

Note: There may be times when more than one of these situations apply to you. When this happens, you may want to choose the protection that gives you the best choice of policies. For example, if both situations #1 and #4 apply to you, you may have the right to buy any Medigap policy. This is because situation #4 offers you the best choice by allowing you to buy any Medigap policy that is sold in your state. Situation #1 limits your choices to only Medigap plans A, B, C, or F that are sold in your state.

Your Health Coverage Situation	Medigap Protections
1. Your Medicare managed care plan or Private Fee-for-Service plan coverage ends because the plan is leaving the Medicare program or will no longer give care in your area.	You may have three choices. (For more information on these three choices, see page 43.) You have the right to buy Medigap plans A, B, C, or F that are sold in your state as long as you apply no later than 63 calendar days from the date on the letter from your plan (for Medicare health plans with a Medicare + Choice contract) or no later than 63 calendar days after your health coverage ends. The insurance company cannot deny you insurance coverage or place conditions on the policy (like making you wait for coverage to start). You must be covered for all pre-existing conditions. You can't be charged more for a policy because of past or present health problems. If you are under age 65 and have Medicare because of a disability or **ESRD**, you must be allowed to buy Medigap plans A, B, C, or F that are sold in your state to people under age 65 with Medicare. Remember, there is no federal law that requires insurance companies to have general Medigap open enrollment periods for people under age 65.

Your Health Coverage Situation	Medigap Protections
2. Your health coverage (like a Medicare managed care plan or Private Fee-for-Service plan, employer group health plan that supplemented or paid some of the costs not paid for by Medicare, Medicare SELECT policy, Program of All-Inclusive Care for the Elderly (PACE), or a Medicare managed care demonstration project) ends through no fault of your own.	You have the right to buy Medigap plans A, B, C, or F that are sold in your state as long as you apply no later than 63 calendar days after your health coverage ends. The insurance company cannot deny you insurance coverage or place conditions on the policy (like making you wait for coverage to start). You must be covered for all pre-existing conditions. You can't be charged more for a policy because of past or present health problems. If you are under age 65 and have Medicare because of a disability or **ESRD**, you must be allowed to buy Medigap plans A, B, C, or F that are sold in your state to people under age 65 with Medicare. **Caution:** In most cases, you must stay in your health plan until the date your coverage ends. If you leave the plan before this date, you may lose your right to buy Medigap plans A, B, C, or F.

Your Health Coverage Situation	Medigap Protections
3. You dropped your Medigap policy to join a Medicare managed care plan or Private Fee-for-Service plan, or buy a Medicare SELECT policy, then leave the plan or policy, and: ■ This is the first time that you have ever been enrolled in a Medicare health plan or Medicare SELECT policy; and ■ You leave the Medicare health plan or Medicare SELECT policy within one year after joining.	You must be allowed to return to your former Medigap policy if it is still available from the same insurance company. You must apply no later than 63 calendar days after your health coverage ends. If it is not available, you have the right to buy Medigap plans A, B, C, or F that are sold in your state as long as you apply no later than 63 calendar days after your Medicare health plan coverage ends. The insurance company cannot deny you insurance coverage or place conditions on the policy (like making you wait for coverage to start). You must be covered for all pre-existing conditions. You can't be charged more for a policy because of past or present health problems. **Caution:** If you bought a Medigap policy before 1990, your policy is probably not a standardized Medigap policy. It may have benefits that are different from the 10 standardized Medigap plans. Therefore, if you dropped it, you would not be able to get it back because that policy is no longer being sold.
4. You joined a Medicare health plan (like a Medicare managed care plan with a Medicare + Choice contract, or a Private Fee-for-Service plan) when you first became eligible for Medicare at age 65, and you leave the plan within one year after joining.	You must be allowed to buy **any** Medigap policy sold in your state as long as you apply no later than 63 calendar days after your Medicare health plan coverage ends. The insurance company cannot deny you insurance coverage or place conditions on the policy (like making you wait for coverage to start). You must be covered for all pre-existing conditions. You can't be charged more for a policy because of past or present health problems. Note: If you are still in your Medigap open enrollment period after you leave your Medicare health plan, you may have more than 63 calendar days to buy a Medigap policy.

All rights to buy Medigap policies under these protections include Medicare SELECT policies since they are a type of Medigap policy.

Using a Medigap Policy

How Your Bills Get Paid

Does the Medigap insurance company pay my doctor directly?

The insurance company will pay your doctor or provider directly when:

- Your doctor or supplier has signed an agreement with Medicare to accept assignment of all Medicare claims for all people with Medicare;
- Your policy is a Medigap policy; and
- You tell your doctor's office to put on the Medicare claim form that you want Medigap insurance benefits paid to the doctor or supplier. Your doctor will put your Medigap policy number and company on the Medicare claim form. You will need to sign the claim form.

When these conditions are met, the Medicare Carrier will process the claim and send it to the Medigap insurance company. The carrier will send you an Explanation of Medicare Benefits (EOMB) or Medicare Summary Notice (MSN). Your Medigap insurance company will pay your doctor or provider directly and then send you a notice. If you don't get this notice, you may ask your Medigap insurance company for it.

In most cases, Medicare claims are sent directly to the insurance company, even if the doctor does not accept assignment (also called a participation agreement).

What happens if the Medigap insurance company does not pay my doctor directly?

If the Medigap insurance company does not pay your doctor directly (when the above three conditions are met), you should report this to your State Insurance Department (see pages 86-87). For more information on Medigap claim filing by the carrier, call your Medicare Carrier (see pages 92-93).

Remember, terms in red are defined on pages 100-103.

Private Contracts

If I sign a private contract with my doctor, will Medicare and Medigap pay?

No. A private contract is an agreement between you and a doctor who has decided not to give services through the Medicare program. The private contract only applies to the services given by the doctor who asked you to sign it. This means that Medicare and Medigap will not pay for the services you get from the doctor with whom you have a private contract. You cannot be asked to sign a private contract in an emergency or for urgently needed care. **Note:** You still have the right to see other Medicare doctors for services.

What happens if I sign a private contract with my doctor?

If you sign a private contract with your doctor:

- No Medicare payment will be made for the services you get from this doctor.
- Your Medigap policy, if you have one, will not pay anything for this service. (Call your insurance company before you get the service.)
- You will have to pay whatever this doctor or provider charges you (the limiting charge will not apply).
- Medicare managed care plans or Private Fee-for-Service plans will not pay for these services.
- No claim should be submitted, and Medicare will not pay if one is.
- Many other insurance plans will not pay for the service either.

Can I pay on my own for services that are not covered by Medicare?

Yes. You may choose to pay on your own for services the Original Medicare Plan doesn't cover. In this case, your doctor does not have to stop giving services through Medicare or ask you to sign a private contract. You are

Remember, terms in red are defined on pages 100-103.

Private Contracts (continued)

always free to get non-Medicare-covered services on your own if you choose to pay for the service yourself.

A Medigap policy will not pay any coinsurance or deductible amounts on the cost of services that would generally be covered by Medicare, but are denied by a Medicare Carrier or Fiscal Intermediary because they are not medically necessary for a particular patient. However, some of the 10 standardized Medigap policies contain certain benefits that provide payment for limited categories of services that are never covered by Medicare. For example, the foreign travel emergency benefit in plans C through J; the outpatient prescription drug benefit in Medigap plans H, I, and J; the at-home recovery benefit in plans D, G, I, and J; and the preventive care benefit in plans E and J all pay for limited categories of non-Medicare-covered services.

Switching Medigap Policies

Can my Medigap insurance company drop me?

In most cases, no. Medigap policies sold after 1990 are required to be guaranteed renewable. This means that your insurance company must let you renew your Medigap policy unless you do not pay the premiums, you lie, or commit fraud under the policy. There is only one situation where you may lose a Medigap guaranteed renewable policy: if the insurance company goes bankrupt. If this happens, you have the right to buy Medigap plans A, B, C, or F that are sold in your state.

Insurance companies may refuse to renew older Medigap policies that were not sold as guaranteed renewable. To do this, an insurance company must decide to cancel all policies of this type sold in your state. If this happens, you have the right to buy Medigap plans A, B, C, or F that are sold in your state (see Example on page 65).

Remember, terms in red are defined on pages 100-103.

Switching Medigap Policies (continued)

Example ▸

In 1987, Mr. Jones bought a Medigap policy from Company A. The Medigap policy Mr. Jones bought was not guaranteed renewable. Company A is no longer offering this type of Medigap policy and wants to cancel all policy contracts of this type. Therefore, Mr. Jones may switch to another Medigap policy. His choices include Medigap policies A, B, C, or F that are sold in his state.

Do I have to switch my older Medigap policy for one of the newer standardized Medigap plans?

No, you do not have to switch your policy.

What should I do before switching my Medigap policy?

Before switching policies, compare benefits and premiums. Some of the older Medigap policies may offer better coverage, especially for prescription drugs and long-term care. On the other hand, older Medigap policies may have bigger premium increases than newer standardized Medigap policies. Older Medigap policies cannot be sold to people who are now buying Medigap insurance.

If I decide to switch my Medigap policy, and then I change my mind, can I go back to my older Medigap policy?

No. If you do switch Medigap policies, you will not be able to go back to your Medigap policy if it was sold to you before 1990.

Remember, terms in red are defined on pages 100-103.

Switching Medigap Policies (continued)

Do I have to have my Medigap policy for a certain length of time before I can switch to a different Medigap policy?

No. However, if you had a Medigap policy for at least 6 months and you decide to switch, your second Medigap policy generally must cover you for all pre-existing conditions. If you had a Medigap policy for less than 6 months, the new policy must give you credit for the time you were covered under the older policy. If there is a benefit in the second Medigap policy that was not in your first policy, the company can make you wait up to 6 months before covering that benefit.

Do I need more than one Medigap policy?

No. It is illegal for insurance companies to sell you a second policy. If you already have a Medigap policy and you want to buy another one, you must sign a statement saying that you plan to cancel your first Medigap policy. Do not cancel your first Medigap policy until the second one is in place, the pre-existing condition waiting period is over, and you decide to keep the second Medigap policy. You have 30 days to decide if you want to keep the new policy. This is called your free look period.

Remember, terms in red are defined on pages 100-103.

Other Kinds of Health Insurance

Group Health Coverage

What kinds of group health coverage are there?

There are several kinds of coverage that might be called "group" health coverage, such as coverage offered under:

- Employers or unions: This type of group health coverage is for current employees or retirees. Generally, employer plans have better rates than you can get if you buy a policy yourself, and employers may pay part of the cost.

- Organizations or associations: This type of group health coverage is for members of an organization or association. Just because you are buying through a group does not always mean that you are getting a lower rate. This type of coverage can cost as much as, or more than, the same coverage you get with a policy you buy yourself. Be sure you understand the benefits included and how the premiums are decided, then compare prices.

What happens if I have employer or union coverage when I turn age 65?

When you reach age 65 you will need to make a decision about Part B (see page 37). You may still have health coverage through your or your spouse's current or active employer or union membership. If you do, be sure to read the information in the sections "Special Enrollment Period" (see page 5), "More on Employee Coverage" (see pages 69-72), and "Who Pays First" (see pages 72-75). Also, find out if your employer coverage can be continued after you retire. Check the price and benefits, including benefits for your spouse. Make sure you know what effect your continued coverage as a retiree will have on his or her insurance protections.

Group Health Coverage (continued)

How does retiree coverage work?

Retiree coverage that is not a Medigap policy does not have to follow the rules for Medigap policies. However, under some circumstances, retiree coverage must follow the rules of the Department of Labor. These plans might not fill the gaps in Medicare. They might not pay your medical costs during any period in which you were eligible for Medicare but did not sign up for it.

While retiree coverage may not offer the same benefits as a Medigap policy, it may offer other benefits such as prescription drug coverage and routine dental care. Keep in mind that the retiree coverage provided by your employer or union may have limits on how much it will pay. It may also provide "stop loss" coverage, or a limit on your out-of-pocket spending after you have already paid a certain amount of out-of-pocket costs.

Note: When you have retiree coverage from an employer or union, they have control over this insurance. They may change the benefits or the premiums and can also cancel the insurance if they choose.

If you are not sure how your plan works with Medicare, get a copy of your plan's benefits booklet, or look at the summary plan description provided by your employer or union. You can also call your benefit administrator and ask how the plan pays when you have Medicare.

What happens if I drop employer-based coverage?

If you drop your employer-based group health coverage, you probably won't be able to get it back. For more information, call your benefit administrator.

Remember, terms in red are defined on pages 100-103.

Group Health Coverage (continued)

What if I buy a Medigap policy while I have retiree coverage?

Although it is generally unwise to buy more insurance than you need, you may buy a Medigap policy even if it has some of the same benefits as your retiree coverage under a group health plan. Your retiree coverage may have a coordination of benefits clause, sometimes called a "carve out." If it does, it will not pay benefits the Medigap policy pays. The Medigap policy must pay full benefits even if the retiree coverage also pays for the same service. You may want to call your benefit administrator or your State Health Insurance Assistance Program (see pages 88-89) before buying a Medigap policy that has the same benefits as your retiree coverage.

More on Employee Coverage

What health benefits must my employer provide if I am age 65 or older and still working?

Employers with 20 or more employees must offer the same benefits, including health benefits under the same conditions, to current or active employees age 65 and over as they offer to younger employees. If they offer coverage to spouses, they must offer the same coverage to spouses age 65 and over that they offer to spouses under age 65. If your employer and/or employer group health coverage does not follow this rule, you should call the Health Care Financing Administration (see page 90).

Note: Sometimes, employee health coverage ends automatically at the end of a calendar year even before you get a notice from your employer that your coverage has ended. This could start the 63 calendar day period for Medigap protections before you even find out you are entitled to them (see pages 47-50). Check with your employer to make sure you understand how your coverage works and how you can protect yourself.

Remember, terms in red are defined on pages 100-103.

More on Employee Coverage (continued)

What happens if I or my spouse stop working, stop group health coverage, and already have Medicare?

You should:

- Call your Medicare Carrier (see pages 92-93) or write a letter telling them that your or your spouse's employment situation has changed.
- Give the carrier the name and address of the employer plan, your policy number with the group health plan, the date coverage stopped, and why.
- When you get health care services, tell the doctor or hospital that Medicare now pays first and should be billed first. Give the date your group health plan coverage stopped.

Note: The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires your employer to send you a Certificate of Creditable Coverage when your group health coverage ends. All the information you need to give to the Medicare Carrier will be on this certificate. If for some reason your employer does not send you a Certificate of Creditable Coverage, you should ask for one. These certificates are free.

What is COBRA?

COBRA (The Consolidated Omnibus Budget Reconciliation Act of 1985) is a law that requires employers with 20 or more employees to let employees and their dependents keep their group health coverage for a time after they leave their group health plan under certain conditions. This is called "continuation coverage." You may have this right if you lose your job or have your working hours reduced, or if you are covered under your spouse's

Remember, terms in red are defined on pages 100-103.

More on Employee Coverage (continued)

plan and your spouse dies or you get divorced. COBRA generally lets you and your dependents keep the group coverage for 18 months (or up to 29 or 36 months in some cases), but you may have to pay both your share and the employer's share of the premium. Some state's laws require employers with less than 20 employees to let you keep your group health coverage for a time, but you should check with your State Insurance Department to make sure (see pages 86-87). In most situations that give you COBRA rights, other than a divorce, you should get a notice from your benefit administrator. If you don't get a notice, or if you get divorced, you should call your benefit administrator as soon as possible.

If you already have continuation coverage under COBRA when you enroll in Medicare, your COBRA may end. This is because the employer has the option of canceling the continuation coverage at this time. The length of time your spouse may get coverage under COBRA may change when you enroll in Medicare. For more information about group health coverage under COBRA, call your State Insurance Department (see pages 86-87).

However, if you elect COBRA coverage after you enroll in Medicare, you can keep your continuation coverage. When your group health coverage ends, you and your dependents can get coverage under COBRA. If you only have Medicare Part A when your group health plan coverage ends (based on **current or active** employment), you can enroll in Medicare Part B during a special enrollment period without having to pay a Part B premium penalty. You need to enroll in Part B **either** at the same time you enroll in Part A **or** during a special enrollment period after your group health plan coverage, based on **current or active** employment, ends. Remember, this will also start your Medigap open enrollment period

Remember, terms in red are defined on pages 100-103.

More on Employee Coverage (continued)

(see page 37). However, if you only have Medicare Part A, sign-up for COBRA coverage and wait until the COBRA coverage ends to enroll in Medicare Part B, **you will have to pay a Part B premium penalty. You do not get a Part B special enrollment period when COBRA coverage ends**. State law may give you the right to continue your coverage under COBRA beyond the point COBRA coverage would ordinarily end. Your rights will depend on what is allowed under the state law.

Who Pays First

Does Medicare or my group health plan pay first?

If you are age 65 or over and covered by a group health plan because of **current or active** employment or the **current or active** employment of a spouse of any age, Medicare is the secondary payer if the employer has 20 or more employees and covers any of the same services as Medicare. This means that the group health plan is the primary payer. It pays first on your hospital and medical bills. Medicare will review what your group health plan paid for Medicare-covered health care services, and pay any additional costs up to the Medicare-approved amount. You will have to pay the costs of services that Medicare or the group health plan does not cover.

If you do not take the group health plan coverage, Medicare will be the primary payer. Medicare will pay its share for any Medicare-covered health care service you get (see pages 97-99 for a list of Medicare-covered services). Your employer can offer you a plan that will pay for services not covered by Medicare such as hearing aids, routine dental care, prescription drugs, and routine physical check-ups. However, the employer cannot offer you a plan that pays supplemental benefits for Medicare-covered services or pays for these benefits in any other way.

Remember, terms in red are defined on pages 100-103.

Who Pays First (continued)

Remember, when you enroll in Medicare Part B, you start your 6-month Medigap open enrollment period (see page 37). To help decide whether to keep your group health plan coverage, talk with your benefit administrator, your State Insurance Department (see pages 86-87), or your State Health Insurance Assistance Program (see pages 88-89).

Who pays first if I'm a disabled Medicare beneficiary under age 65?

Medicare pays first if you are under age 65, have Medicare because of a disability, and your group health plan coverage is through an employer with fewer than 100 employees. If the employer has 100 employees or more, the health plan is called a large group health plan (LGHP). If you are covered by a LGHP because of your current employment or the current employment of a family member, Medicare pays second. Sometimes employers with fewer than 100 employees join other employers in a LGHP. If at least one employer in the LGHP has 100 employees or more, then Medicare always pays second. Some LGHPs let others join the plan such as a self-employed person, a business associate of an employer, or a family member of one of these people. A LGHP cannot treat any of their plan members differently because they are disabled and have Medicare.

Who pays first if I have Medicare because of End-Stage Renal Disease (ESRD), and have group health coverage?

If you are eligible to enroll in Medicare because of ESRD (permanent kidney failure), your group health plan will pay first on your hospital and medical bills for 30 months whether or not you are enrolled in

Remember, terms in red are defined on pages 100-103.

Who Pays First (continued)

Medicare and have a Medicare card. During this time, Medicare is the secondary payer. The group health plan pays first during this period no matter how many employees work for the employer, or whether you or a family member are currently employed. At the end of the 30 months, Medicare becomes the primary payer. This only applies to those with ESRD, whether you have your own group health coverage or you are covered as a family member.

For more information on ESRD, you can get a free copy of *Medicare Coverage of Kidney Dialysis and Kidney Transplant Services* by calling 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired). You can also see and print a copy of this booklet by using a computer to look on the Internet at www.medicare.gov.

If you don't have a computer, your local library or senior center may be able to help you look at this information.

Know Who Pays If You Have Other Health Insurance

If you...	Condition	Pays first	Pays second
Are age 65 or older and covered by a group health plan because you are working or are covered by a group health plan of a working spouse of any age	■ The employer has fewer than 20 employees	■ Medicare	■ Group health plan
	■ The employer has 20 or more employees	■ Group health plan	■ Medicare
Are disabled and covered by a large group health plan (LGHP) because you are working or because of a family member who is working	■ The employer has fewer than 100 employees	■ Medicare	■ Group health plan
	■ At least one employer covered by the plan has 100 or more employees	■ Large group health plan	■ Medicare
Have End-Stage Renal Disease (permanent kidney failure) and group health plan coverage (including a retirement plan)	■ First 30 months of eligibility or entitlement to Medicare	■ Group health plan	■ Medicare
	■ After 30 months	■ Medicare	■ Group health plan
Have an employer retiree plan and are age 65 or older or are disabled	■ Eligible for Medicare	■ Medicare	■ Retiree coverage

Chart modified and used with permission from the Medicare Rights Center, Inc.

If you have Medicare and group health plan coverage **be sure to tell your doctor and other providers so your bills can be sent to the appropriate payer to avoid delays.**

Other Health Insurance Options

New in 2000:

If you are over age 65 and in a PACE program that leaves the Medicare program or stops giving care in your area, you have the right to buy Medigap plans A, B, C, or F that are sold in your state. You must apply no later than 63 calendar days after your health coverage ends (see pages 47-50).

What is the PACE program?

The Programs of All-Inclusive Care for the Elderly (PACE) is a program that combines both inpatient and outpatient medical and long-term care services. To be eligible, you must be at least 55 years old, live in the service area of the PACE program, and be certified as eligible for nursing home care by the appropriate state agency. The goal of PACE is to keep you independent and living in your community as long as possible and to offer quality care at low cost.

Services include primary care, social work, therapy to help you get better, medical services for special problems, medical services that support routine treatment, and long-term care services (such as transportation, meals, and personal care). The services are given in the PACE center, at home, and in other inpatient settings such as a hospital.

A team of health care providers looks at your needs, makes a plan of care, and gives you services for the total care that you need. This health care team includes, but is not limited to, doctors, nurses, therapists, and social workers. If you need nursing home care, PACE will give you this service and check your health condition on a regular basis.

PACE sites get payments directly from Medicare and Medicaid for services that all eligible enrollees get. However, PACE sites are only in certain communities. To find a PACE site near you, or for more information, call your state, county, or local medical assistance office - not a federal office. You can also use a computer to look on the Internet under the Nursing Home section of www.medicare.gov for PACE locations and telephone numbers.

Remember, PACE does not work with Medigap policies.

Other Health Insurance Options (continued)

What is a Federally Qualified Health Center?

Another possible way to lower your health care costs is to go to a Federally Qualified Health Center (FQHC). At a FQHC, you can get routine care. When you use a FQHC, Medicare pays for some health services like preventive care that are not usually covered. FQHCs include community health centers, tribal health clinics, migrant health services, and health centers for the homeless. Anyone with Medicare may go to a FQHC for health care services. They are usually in inner-city and rural areas. FQHC services that are available to people with Medicare include:

- Routine physical exams.
- Screening and diagnostic tests for vision and hearing problems, and other health problems.
- Flu shots and other similar shots.

When you get these services at a FQHC, you do not have to pay the $100 yearly Part B deductible. If you get other services like X-rays, you will have to pay the usual Part B yearly deductible of $100. Sometimes you will not have to pay the 20 percent coinsurance for Part B services.

To find the FQHC nearest to you, call 1-800-MEDICARE (1-800-633-4227, TTY/TDD 1-877-486-2048 for the hearing and speech impaired). Ask for the telephone number of the Primary Care Association in your state.

Can I get help paying health care costs for young children in my care who don't have insurance?

If you have young children under age 19 in your care who don't have insurance, you may be able to get help to pay for their health care costs under your State Children's Health Insurance Program.

Health Insurance For Children under Age 19

A new State Children's Health Insurance Program is now available. Call 1-877-KIDS-NOW (1-877-543-7669) or look on the Internet at www.insurekidsnow.gov for more details.

Other Health Insurance Options (continued)

How can Medicaid help Medicare beneficiaries?

Medicaid is a joint federal and state program that helps pay medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state. Most of your health care costs are covered if you qualify for both Medicare and Medicaid. People on Medicaid may also get coverage for nursing home care and outpatient prescription drugs which are not covered by Medicare.

Some of these programs may not be available in Guam, Puerto Rico, the Virgin Islands, the Northern Mariana Islands, and American Samoa.

States also have programs that pay some or all of Medicare's premiums and may also pay Medicare deductibles and coinsurance for certain people who have Medicare and a low income. To qualify for these programs, you must:

- Have Medicare Part A (hospital insurance). If you're not sure if you have Part A, look on your red, white, and blue Medicare card or call the Social Security Administration at 1-800-772-1213.
- Have a monthly income of less than $1,238 for an individual or $1,661 for a couple. These income limits are slightly higher in Hawaii and Alaska. (These income limits will change slightly in 2001.)
- Have savings of $4,000 or less for an individual or $6,000 or less for a couple. Savings include money in a checking or savings account, stocks, or bonds.

Call your nearest medical assistance office if you think you qualify.

If you want more information on these programs, call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) and ask for information on "Savings for Medicare Beneficiaries."

Other Health Insurance Options (continued)

What should I do if I have a Medigap policy and then go on Medicaid?

If you have a Medigap policy and go on Medicaid, you have the right to suspend the Medigap policy rather than dropping it while you are on Medicaid. However, in some cases, it may not be a good idea to suspend your Medigap policy. Call your state medical assistance office to help you with this decision.

If you do suspend your policy, while it is suspended, you do not pay premiums and it will not pay benefits. You can only suspend a Medigap policy for up to 2 years. At the end of the suspension, you can start it up again without new medical underwriting or pre-existing condition waiting periods. Call your insurance company to find out how to suspend a policy.

Can an insurance company sell me a Medigap policy if I already have Medicaid?

If you have Medicaid, an insurance company can sell you a Medigap policy **only** in certain situations (see chart below).

If...	Then you can buy...
Medicaid pays your Medigap premium	Any Medigap policy
Medicaid pays your Medicare premiums, deductibles, and coinsurance	Medigap plans H, I, or J
Medicaid pays all or part of your Medicare Part B premium	Any Medigap policy

In any other situation, it is illegal for an insurance company to sell you a Medigap policy if you have Medicaid.

Other Private Health Insurance Options

The following types of policies are generally limited in scope and are not substitutes for Medigap insurance or comprehensive health coverage. Benefits under these policies are not designed to fill gaps in your Medicare coverage.

What is hospital indemnity insurance?

- Hospital indemnity insurance pays a fixed cash amount for each day you are in the hospital up to a certain number of days. Some policies may have added benefits such as surgical benefits or skilled nursing home confinement benefits. Some policies have a maximum number of days or a maximum payment amount.

What is specified disease insurance?

- Specified disease insurance, which is only available in some states, pays benefits for only one disease, such as cancer, or for a group of specified diseases. The value of this coverage depends on the chance you will get the specific disease or diseases covered. Benefits are usually limited to a fixed amount for each type of treatment. Remember, Medicare and any Medigap policy you have will very likely cover costs from any specified diseases you may have.

Long-Term Care Insurance

Remember, terms in red are defined on pages 100-103.

What is long-term care?

Long-term care is different from traditional medical care. Someone with a long physical illness, or a disability, or a memory or thought problem (such as Alzheimer's disease) often needs long-term care. Long-term care is made up of many different services to help people with chronic conditions overcome limitations that keep them from being independent. Long-term care may include help with activities of daily living,

Long-Term Care Insurance (continued)

home health care, respite care, adult day care, care in a nursing home, and care in an assisted living facility. Long-term care may also include case management services, which will evaluate your needs and coordinate and monitor the delivery of long-term care services.

Does Medicare cover long-term care?

No. Generally, Medicare only covers medically necessary care under Part A (Hospital Insurance) and Part B (Medical Insurance). You must meet certain conditions for Medicare to cover skilled nursing facility, home health, and hospice care (see pages 97-99).

What is long-term care insurance?

Long-term care insurance is one way you may pay for long-term care. This type of insurance will pay for some or all of your long-term care. Long-term care insurance is a relatively new type of insurance. It was introduced in the 1980s as nursing home insurance. It has changed a lot and now often covers much more than nursing home care.

If you are shopping for long-term care insurance, find out which types of long-term care services the different policies cover. For more information about long-term care insurance, get a copy of *A Shopper's Guide to Long-Term Care Insurance* from either your State Insurance Department (see pages 86-87) or the National Association of Insurance Commissioners, 120 W. 12th Street, Suite 1100, Kansas City, MO 64105-1925. You may also get a copy of *Your Guide to Choosing a Nursing Home* from the Health Care Financing Administration by calling 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired).

Remember, terms in red are defined on pages 100-103.

Long-Term Care Insurance (continued)

Who sells long-term care insurance?

Private insurance companies sell long-term care insurance policies. You can buy them from an insurance agent or through the mail. Or, you can buy a group policy through an employer or through membership in an association. You can also get long-term care benefits through a life insurance policy. Insurance companies must be licensed in your state to sell long-term care insurance. Be certain that you are dealing with a company that you know. If you decide to buy long-term care insurance, be sure that the company and the agent, if one is involved, is licensed in your state. If you are not sure, call your State Insurance Department (see pages 86-87).

New in 2000! ▸

How can I find out about nursing homes in my area?

You can now get important information about the nursing homes in your area by using a computer to look on the Internet at www.medicare.gov. Click on "Nursing Home Compare" to see where nursing homes are located in your area, how big they are, what types of residents they have, and whether or not the nursing home accepts Medicare or Medicaid. With "Nursing Home Compare," you can also see nursing home inspection reports that can tell you if any problems were found during the inspection. If you don't have a computer, your local library or senior center may be able to help you look at this information.

Watch Out for Illegal Insurance Practices

It is illegal for anyone to:

- Sell you a second Medigap policy when they know that you already have one, unless you tell the insurance company in writing that you plan to cancel your existing Medigap policy.
- Sell you a Medigap policy if they know you have Medicaid except in certain situations (see page 79).
- Sell you a Medigap policy if they know you are enrolled in a Medicare managed care plan with a Medicare + Choice contract or Private Fee-for-Service plan.
- Claim that a Medigap policy is part of the Medicare program or any other federal program.
- Use the mail to advertise Medigap policies that are not approved for sale in your state.
- Misuse the names, letters, symbols, or emblems of the U.S. Department of Health and Human Services (DHHS), Social Security Administration (SSA), Health Care Financing Administration (HCFA), or any of their various programs like Medicare.

You should report any suspected violations of the laws on marketing insurance policies to your State Insurance Department (see pages 86-87).

If you believe that a federal law has been violated, you may call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired). In most cases, however, your State Insurance Department can help you with insurance-related problems (see pages 86-87).

Discrimination

Every facility or agency that participates in the Medicare program must comply with the law. It's illegal to discriminate on the basis of race, color, sex, national origin, disability, or age. If you believe that you have been discriminated against based on any of these categories, contact the Department of Health and Human Services, Office of Civil Rights at 1-800-368-1019 (TTY/TDD: 1-800-537-7697 for the hearing and speech impaired).

Who to Call for Medicare or Medigap Information

On the next 8 pages you will find the telephone numbers you may call for Medicare and Medigap information. If you are in a Medicare health plan like a managed care plan or a Private Fee-for-Service plan, you should call your plan with questions about bills, health services, and appeals.

CALL...	IF YOU HAVE QUESTIONS ABOUT...	SEE PAGE...
State Insurance Department	Medigap policies sold in your area and insurance-related problems.	86-87
State Health Insurance Assistance Program	Buying a Medigap policy or long-term care insurance, dealing with payment denials or appeals, Medicare rights and protections, your care or treatment, choosing a Medicare health plan, or Medicare bills.	88-89
Health Care Financing Administration Regional Offices	Local seminars and health fairs on Medicare health plan choices, or to report a complaint directly to the Health Care Financing Administration.	90
State Agencies on Aging	Services for older persons.	91
Medicare Carrier	Medicare Part B coverage, bills, and medical services, or how to recognize Medicare fraud and abuse.	92-93

At the time of printing, telephone numbers listed were correct. Phone numbers sometimes change. To get the most updated phone numbers, call 1-800-MEDICARE (1-800-633-4227 or TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) or go to the Internet at www.medicare.gov and click on "Important Contacts."

State Insurance Department: Call with questions about the Medigap policies sold in your area and any insurance-related problems.

ALABAMA
1(334)241-4101

ALASKA
1(800)467-8725
in-state calls only
TTY/TDD:
1(907)465-5437

AMERICAN SAMOA
1(808)586-2790

ARIZONA
1(800)325-2548
in-state calls only

ARKANSAS
1(800)852-5494

CALIFORNIA
1(800)927-4357
in-state calls only
TTY/TDD:
1(800)482-4000

COLORADO
1(800)930-3745
in-state calls only

CONNECTICUT
1(800)203-3447
in-state calls only

DELAWARE
1(800)282-8611
in-state calls only

FLORIDA
1(800)342-2762
in-state calls only
TTY/TDD:
1(800)640-0886

GEORGIA
1(800)656-2298
in-state calls only
TTY/TDD:
1(404)656-4031

GUAM
1(808)586-2790

HAWAII
1(808)586-2790

IDAHO
1(800)445-6941
TTY/TDD:
1(800)377-3529

ILLINOIS
1(217)782-4515
TTY/TDD:
1(217)524-4872

INDIANA
1(800)622-4461
in-state calls only

IOWA
1(515)281-5705

KANSAS
1(800)432-2484
in-state calls only
TTY/TDD:
1(877)235-3151

KENTUCKY
1(800)595-6053
TTY/TDD:
1(800)462-2081

LOUISIANA
1(800)259-5301
in-state calls only

MAINE
1(800)300-5000
in-state calls only
TTY/TDD:
1(207)624-8563

MARYLAND
1(800)492-6116
TTY/TDD:
1(800)735-2258

MASSACHUSETTS
1(617)521-7794
TTY/TDD:
1(617)521-7490

MICHIGAN
1(877)999-6442

MINNESOTA
1(651)296-4026
TTY/TDD:
1(651)296-2860

MISSISSIPPI
1(800)562-2957
in-state calls only

MISSOURI
1(800)726-7390
TTY/TDD:
1(573)526-4536

MONTANA
1(800)332-6148
in-state calls only
TTY/TDD:
1(406)444-3246

NEBRASKA
1(800)234-7119
TTY/TDD:
1(800)833-7352

NEVADA
1(800)992-0900
in-state calls only

NEW HAMPSHIRE
1(800)852-3416
TTY/TDD:
1(800)735-2964

NEW JERSEY
1(609)292-5360

NEW MEXICO
1(800)947-4722
in-state calls only

NEW YORK
1(800)342-3736
in-state calls only
TTY/TDD:
1(212)480-4728

NORTH CAROLINA
1(800)443-9354
in-state calls only
TTY/TDD:
1(919)715-0319

NORTH DAKOTA
1(800)247-0560
in-state calls only
TTY/TDD:
1(800)366-6888

NORTHERN MARIANA ISLANDS
1(808)586-2790

OHIO
1(800)686-1578
in-state calls only

OKLAHOMA
1(800)522-0071
in-state calls only

OREGON
1(800)722-4134
in-state calls only

PENNSYLVANIA
1(877)881-6388
in-state calls only
TTY/TDD:
1(814)871-4897

PUERTO RICO
1(787)722-8686

RHODE ISLAND
1(401)222-2223
TTY/TDD:
1(401)222-2999

State Insurance Department: Call with questions about the Medigap policies sold in your area and any insurance-related problems.

SOUTH CAROLINA
1(800)768-3467
in-state calls only
TTY/TDD:
1(803)737-5769

SOUTH DAKOTA
1(605)773-3563

TENNESSEE
1(800)525-2816

TEXAS
1(800)252-3439
TTY/TDD:
1(512)463-6515

UTAH
1(800)439-3805
in-state calls only
TTY/TDD:
1(801)538-3826

VERMONT
1(800)631-7788
in-state calls only

VIRGIN ISLANDS
1(340)774-7166

VIRGINIA
1(800)552-7945
in-state calls only
TTY/TDD:
1(804)371-9206

WASHINGTON
1(800)397-4422
in-state calls only

WASHINGTON D.C.
1(202)727-8000

WEST VIRGINIA
1(800)642-9004
in-state calls only
TTY/TDD:
1(800)435-7381

WISCONSIN
1(800)236-8517
in-state calls only
TTY/TDD:
1(800)947-3529

WYOMING
1(800)438-5768
in-state calls only

State Health Insurance Assistance Program: Call for help with buying a Medigap policy or long-term care insurance, dealing with payment denials or appeals, Medicare rights and protections, help with complaints about your care or treatment, for help choosing a Medicare health plan, or Medicare bills.

ALABAMA
1(800)243-5463
in-state calls only
TTY/TDD:
1(334)242-0995

ALASKA
1(800)478-6065
in-state calls only

AMERICAN SAMOA
1(808)586-7299

ARIZONA
1(800)432-4040
TTY/TDD:
1(602)542-6366

ARKANSAS
1(800)224-6330

CALIFORNIA
1(800)434-0222

COLORADO
1(888)696-7213

CONNECTICUT
1(800)994-9422
in-state calls only
TTY/TDD:
1(860)842-5424

DELAWARE
1(800)336-9500
in-state calls only

FLORIDA
1(800)963-5337
in-state calls only
TTY/TDD:
1(850)414-2001

GEORGIA
1(800)669-8387
in-state calls only

GUAM
1(808)586-7299

HAWAII
1(808)586-7299

IDAHO
1(800)247-4422
in-state calls only
TTY/TDD:
1(800)377-3529

ILLINOIS
1(800)548-9034
in-state calls only
TTY/TDD:
1(217)524-4872

INDIANA
1(800)452-4800

IOWA
1(800)351-4664

KANSAS
1(800)860-5260
in-state calls only
TTY/TDD:
1(877)235-3151

KENTUCKY
1(502)564-7372

LOUISIANA
1(800)259-5301
in-state calls only

MAINE
1(800)750-5353

MARYLAND
1(800)243-3425
in-state calls only
TTY/TDD:
1(410)767-1083

MASSACHUSETTS
1(800)882-2003
in-state calls only
TTY/TDD:
1(800)872-0166

MICHIGAN
1(800)803-7174
TTY/TDD:
1(517)373-4096

MINNESOTA
1(800)333-2433
TTY/TDD:
1(800)627-3529

MISSISSIPPI
1(800)948-3090

MISSOURI
1(800)390-3330

MONTANA
1(800)332-2272
in-state calls only
TTY/TDD:
1(800)833-8503

NEBRASKA
1(800)234-7119
TTY/TDD:
1(800)833-7352

NEVADA
1(800)307-4444

NEW HAMPSHIRE
1(800)852-3388
in-state calls only

NEW JERSEY
1(800)792-8820
in-state calls only

NEW MEXICO
1(800)432-2080
in-state calls only

NEW YORK
1(800)333-4114

NORTH CAROLINA
1(800)443-9354
in-state calls only
TTY/TDD:
1(919)715-0319

NORTH DAKOTA
1(800)247-0560
in-state calls only
TTY/TDD:
1(800)366-6888

NORTHERN MARIANA ISLANDS
1(808)586-7299

OHIO
1(800)686-1578
in-state calls only

OKLAHOMA
1(800)763-2828
in-state calls only

OREGON
1(800)722-4134
in-state calls only
TTY/TDD:
1(503)954-5832

PENNSYLVANIA
1(800)783-7067

PUERTO RICO
1(877)725-4300
in-state calls only

RHODE ISLAND
1(800)322-2880
in-state calls only

SOUTH CAROLINA
1(800)868-9095
in-state calls only

SOUTH DAKOTA
1(800)822-8804

TENNESSEE
1(800)525-2816

TEXAS
1(800)252-9240

State Health Insurance Assistance Program: Call for help with buying a Medigap policy or long-term care insurance, dealing with payment denials or appeals, Medicare rights and protections, help with complaints about your care or treatment, for help choosing a Medicare health plan, or Medicare bills.

UTAH
1(800)541-7735
in-state calls only

WYOMING
1(800)856-4398

VERMONT
1(800)642-5119
in-state calls only
1(802)748-5182
out-of-state calls only

VIRGIN ISLANDS
1(340)778-6311
x2338

VIRGINIA
1(800)552-3402

WASHINGTON
1(800)397-4422
in-state calls only
TTY/TDD:
1(360)493-2637

WASHINGTON D.C.
1(202)676-3900

WEST VIRGINIA
1(877)987-4463

WISCONSIN
1(877)333-6202

Health Care Financing Administration (HCFA) Regional Offices: Call for information about local seminars and health fairs on Medicare health plan choices, or to report a complaint directly to HCFA.

If you live in:	The Regional Office is in:	The phone number is:
Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont	Boston	1(617)565-1232
New Jersey, New York, Puerto Rico, Virgin Islands	New York	1(212)264-3657
Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia	Philadelphia	1(215)861-4226
Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee	Atlanta	1(404)562-7500
Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin	Chicago	1(312)353-7180 TTY/TDD: 1(312)353-2185
Arkansas, Louisiana, New Mexico, Oklahoma, Texas	Dallas	1(214)767-6401
Iowa, Kansas, Missouri, Nebraska	Kansas City	1(816)426-2866
Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming	Denver	1(303)844-4024 TTY/TDD: 1(800)659-3656
American Samoa, Arizona, California, Guam, Hawaii, Nevada, Northern Mariana Islands	San Francisco	1(415)744-3602
Alaska, Idaho, Oregon, Washington	Seattle	1(206)615-2354

State Agencies On Aging: Call for information on services for older persons.

ALABAMA 1(800)243-5463	FLORIDA 1(850)414-2000	LOUISIANA 1(504)564-3220	NEVADA 1(702)486-3545	OREGON 1(800)232-3020	VIRGINIA 1(804)662-9333
ALASKA 1(800)478-6065	GEORGIA 1(404)657-5258	MAINE 1(207)624-5335	NEW HAMPSHIRE 1(603)271-4680	PENNSYLVANIA 1(717)783-1550	VIRGIN ISLANDS 1(809)692-5950
AMERICAN SAMOA 1(684)633-1252	GUAM 011(671)475-0263	MARYLAND 1(800)243-3425	NEW JERSEY 1(609)588-3139	PUERTO RICO 1(787)721-5710	WASHINGTON 1(360)664-2168
ARIZONA 1(602)542-4446	HAWAII 1(808)586-0100	MASSACHUSETTS 1(617)727-7750	NEW MEXICO 1(505)827-7640	RHODE ISLAND 1(401)222-2858	WASHINGTON D.C. 1(202)724-5622
ARKANSAS 1(800)482-6359	IDAHO 1(208)334-3833	MICHIGAN 1(517)373-8230	NEW YORK 1(800)342-9871	SOUTH CAROLINA 1(800)868-9095	WEST VIRGINIA 1(304)558-3317
CALIFORNIA 1(800)510-2020	ILLINOIS 1(217)785-3356	MINNESOTA 1(800)882-6262	NORTH CAROLINA 1(919)733-3983	SOUTH DAKOTA 1(605)773-3656	WISCONSIN 1(608)266-2536
COLORADO 1(303)620-4147	INDIANA 1(317)232-7020	MISSISSIPPI 1(601)359-4929	NORTH DAKOTA 1(800)755-8521	TENNESSEE 1(615)741-2056	WYOMING 1(307)777-7986
CONNECTICUT 1(800)443-9946	IOWA 1(515)281-5187	MISSOURI 1(573)751-3082	NORTHERN MARIANA ISLANDS 1(607)234-6011	TEXAS 1(512)424-6840	
DELAWARE 1(800)223-9074	KANSAS 1(785)296-4986	MONTANA 1(406)444-7781	OHIO 1(614)466-5500	UTAH 1(801)538-3910	
	KENTUCKY 1(502)564-6930	NEBRASKA 1(402)471-2307	OKLAHOMA 1(405)521-2327	VERMONT 1(802)241-2400	

Medicare Carriers: Call about questions on Medicare Part B coverage, bills, and medical services, or for information on how to recognize Medicare fraud and abuse.

ALABAMA
Blue Cross/Blue Shield of Alabama
1(800)292-8855
TTY/TDD: 1(800)548-2547

ALASKA
Noridian Mutual Insurance Company
1(800)444-4606
TTY/TDD: 1(303)858-5903

AMERICAN SAMOA
Noridian Mutual Insurance Company
1(800)444-4606
TTY/TDD: 1(303)858-5903

ARIZONA
Noridian Mutual Insurance Company
1(800)444-4606
TTY/TDD: 1(303)858-5903

ARKANSAS
Blue Cross/Blue Shield Of Arkansas
1(800)482-5525 in-state calls only
TTY/TDD: 1(888)476-3009

CALIFORNIA
National Heritage Insurance Co
1(800)952-8627 Rest of state
TTY/TDD: 1(530)634-7538
Transamerica Occidental Life
1(800)675-2266 Counties of Los Angeles, Orange, San Diego, Ventura, Imperial, San Luis Obispo & Santa Barbara
TTY/TDD: 1(800)410-9600

COLORADO
Noridian Mutual Insurance Company
1(800)332-6681
TTY/TDD: 1(303)858-5903

CONNECTICUT
United Health Care
1(800)982-6819 in-state calls only
TTY/TDD: 1(203)639-3059

DELAWARE
Trailblazer Health Enterprises
1(800)444-4606
TTY/TDD: 1(215)596-5195

FLORIDA
Blue Cross & Blue Shield
1(800)333-7586 in-state calls only
TTY/TDD: 1(800)754-7820

GEORGIA
Cahaba Govt Benefit Adminstr.
1(800)727-0827
TTY/TDD: 1(800)255-0056

GUAM
Noridian Mutual Insurance Company
1(800)444-4606
TTY/TDD: 1(303)858-5903

HAWAII
Noridian Mutual Insurance Company
1(800)444-4606
TTY/TDD: 1(303)858-5903

IDAHO
Cigna Medicare
1(800)627-2782 in-state calls only
TTY/TDD: 1(800)686-5485

ILLINOIS
Wisconsin Physicians Service
1(800)642-6930
TTY/TDD: 1(800)535-6152

INDIANA
Adminastar Federal
1(800)622-4792
TTY/TDD: 1(317)841-4677

IOWA
Noridian Mutual Insurance Company
1(800)532-1285
TTY/TDD: 1(303)858-5903

KANSAS
Blue Cross & Blue Shield Of Kansas
1(800)432-3531 in-state calls only
TTY/TDD: 1(800)430-8757

KENTUCKY
Adminastar Federal
1(800)999-7608
TTY/TDD: 1(502)329-8713

LOUISIANA
Louisiana Medicare - Part B
1(800)462-9666 in-state calls only
TTY/TDD: 1(255)231-2292

MAINE
National Heritage Insurance Company
1(800)882-1228
TTY/TDD: 1(800)559-0443

MARYLAND
Trailblazer Health Enterprises
1(800)444-4606
TTY/TDD: 1(215)596-5195

MASSACHUSETTS
National Heritage Insurance Company
1(800)882-1228
TTY/TDD: 1(800)559-0443

MICHIGAN
Wisconsin Physicians Service
1(800)482-4045
TTY/TDD: 1(800)535-6152

MINNESOTA
United Health Care
1(800)352-2762 in-state calls only
TTY/TDD: 1(800)627-3529

MISSISSIPPI
United Health Care
1(800)682-5417 in-state calls only
TTY/TDD: 1(601)977-5820

MISSOURI
Blue Cross & Blue Shield
1(800)892-5900 in-state calls only
1(800)432-0216 Kansas City calls only
TTY/TDD: 1(800)430-8757
Blue Cross Blue Shield Of Arkansas
1(800)392-3070; St. Louis City and County; Jefferson County
TTY/TDD: 1(314)212-1875

MONTANA
Blue Cross & Blue Shield Of Montana
1(800)332-6146 in-state calls only
TTY/TDD: 1(800)238-5086

Medicare Carriers: Call about questions on Medicare Part B coverage, bills, and medical services, or for information on how to recognize Medicare fraud and abuse.

NEBRASKA
Blue Cross & Blue Shield
1(800)633-1113
TTY/TDD: 1(800)430-8757

NEVADA
Noridian Mutual Insurance Company
1(800)444-4606
TTY/TDD: 1(303)858-5903

NEW HAMPSHIRE
National Heritage Insurance Company
1(800)882-1228
TTY/TDD: 1(800)559-0443

NEW JERSEY
Empire Medicare Services - New Jersey Operations 1(800)462-9306
TTY/TDD: 1(800)992-0165

NEW MEXICO
Blue Cross And Blue Shield Of Arkansas
1(800)423-2925
TTY/TDD: 1(800)822-9472

NEW YORK
Blue Cross Blue Shield
1(800)252-6550 Services Upstate NY
TTY/TDD: 1(607)766-6260
Empire Medicare Services
1(800)442-8430 Services downstate NY, TTY/TDD: 1(516)244-5101
Group Health Inc.
1(800)632-5572 Queens county only

NORTH CAROLINA
Cigna Medicare
1(800)672-3071 in-state calls only
TTY/TDD: 1(800)686-5517

NORTH DAKOTA
Noridian Mutual Insurance Company
1(800)247-2267
TTY/TDD: 1(303)858-5903

NORTHERN MARIANA ISLANDS
Noridian Mutual Insurance Company
1(800)444-4606
TTY/TDD: 1(303)858-5903

OHIO
Nationwide Mutual Insurance Co
1(800)282-0530
TTY/TDD: 1(800)542-5250

OKLAHOMA
Blue Cross And Blue Shield Of Arkansas, 1(800)522-9079
TTY/TDD: 1(800)822-9472

OREGON
Noridian Mutual Insurance Company
1(800)444-4606
TTY/TDD: 1(303)858-5903

PENNSYLVANIA
Xact Medicare Services
1(800)746-5680
TTY/TDD: 1(800)242-8471

PUERTO RICO
Triple S Inc.
1(800)981-7015 in-state calls only

RHODE ISLAND
Blue Cross & Blue Shield Of Rhode Island, 1(800)662-5170
TTY/TDD: 1(888)239-3356

SOUTH CAROLINA
Palmetto Government Benefits Administration, 1(800)868-2522
TTY/TDD: 1(800)223-1296

SOUTH DAKOTA
Noridian Mutual Insurance Company
1(800)437-4762
TTY/TDD:1(303)858-5903

TENNESSEE
Cigna Medicare
1(800)627-2782 in-state calls only
TTY/TDD: 1(800)686-5485

TEXAS
Trailblazer Health Enterprises
1(800)442-2620
TTY/TDD: 1(800)516-6684

UTAH
Blue Cross & Blue Shield
1(800)426-3477
TTY/TDD: 1(800)346-4128

VERMONT
National Heritage Insurance Company
1(800)882-1228
TTY/TDD: 1(800)559-0443

VIRGIN ISLANDS
Triple S, Inc.
1(800)474-7448 in-state calls only

VIRGINIA
Trailblazer Health Enterprises
1(800)444-4606
TTY/TDD: 1(215)596-5195
United Healthcare/Travelers Insurance
1(800)552-3423 in-state calls only
TTY/TDD: 1(804)327-2142

WASHINGTON
Noridian Mutual Insurance Company, 1(800)444-4606
TTY/TDD: 1(303)858-5903

WASHINGTON D.C.
Trailblazer Health Enterprises
1(800)444-4606
TTY/TDD: 1(215)596-5195

WEST VIRGINIA
Nationwide Mutual Insurance Company
1(800)848-0106
TTY/TDD: 1(800)542-5250

WISCONSIN
Wisconsin Physicians Service
1(800)944-0051 in-state calls only
TTY/TDD: 1(800)828-2837

WYOMING
Noridian Mutual Insurance Company
1(800)442-2371
TTY/TDD:1(303)858-5903

MASSACHUSETTS STANDARDIZED MEDIGAP PLANS

Basic Benefits - Included in all plans:

- Hospitalization: Part A coinsurance plus coverage for 365 additional days during your lifetime after Medicare benefits end ✓
- Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) ✓
- Blood: First 3 pints of blood each year ✓

Medigap Benefits	Core	Supplement 1	Supplement 2
Basic Benefits	✓	✓	✓
Part A: Inpatient Hospital Deductible		✓	✓
Part A: Skilled Nursing Facility Coinsurance		✓	✓
Part B: Deductible		✓	✓
Foreign Travel Emergency		✓	✓
Inpatient Days in Mental Health Hospitals	60 days per calendar year	120 days per benefit year	120 days per benefit year
Prescription Drugs ($35 deductible each calendar quarter, then 100% coverage for generic drugs and 80% coverage for brand name drugs)			✓
State-Mandated Benefits (Annual Pap Smear tests and mammograms. Check your plan for other state-mandated benefits.)	✓	✓	✓

For more information on these policies, call your State Insurance Department (see pages 86-87) or look on the Internet at www.medicare.gov and click on "Medigap Compare."

MINNESOTA STANDARDIZED MEDIGAP PLANS

Basic Benefits - Included in all plans:

- Hospitalization: Part A coinsurance ✓
- Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) ✓
- Blood: First 3 pints of blood each year ✓

Medigap Benefits	Basic	Extended Basic
Basic Benefits	✓	✓
Part A: Inpatient Hospital Deductible		✓
Part A: Skilled-Nursing Facility Coinsurance	✓	✓
Part B: Deductible		✓
Foreign Travel Emergency	80%	80%
Outpatient Mental Health	50%	50%
Usual and Customary Fees		80%
Preventive Care	✓	✓
Prescription Drugs		80%
At-home Recovery		✓
Physical Therapy	20%	20%
Coverage while in a Foreign Country		80%

For more information on these policies, call your State Insurance Department (see pages 86-87) or look on the Internet at www.medicare.gov and click on "Medigap Compare."

Optional Riders

- Part A: Inpatient Hospital Deductible
- Part A: Deductible
- Usual and Customary Fees
- Preventive Care
- Prescription Drugs
- At-home recovery

Insurance companies are allowed to offer six additional riders that can be added to a Basic plan. You may choose any one or all of the riders to design a Medigap plan that meets your needs.

WISCONSIN STANDARDIZED MEDIGAP PLANS

Basic Benefits - Included in all plans:

- Hospitalization: Part A coinsurance ✓
- Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) ✓
- Blood: First 3 pints of blood each year ✓

Medigap Benefits	Basic Plan
Basic Benefits	✓
Part A: Skilled-Nursing Facility Coinsurance	✓
Inpatient Mental Health Coverage	175 days per lifetime in addition to Medicare
Home Health Care	40 visits in addition to those paid by Medicare
Part B: Coinsurance	✓
Outpatient Mental Health	✓
Prescription Drugs	✓

For more information on these policies, call your State Insurance Department (see pages 86-87) or look on the Internet at www.medicare.gov and click on "Medigap Compare."

Optional Riders

- Medicare Part A Deductible Rider
- Additional Home Health Care Rider (365 visits including those paid by Medicare)
- Medicare Part B Deductible Rider
- Medicare Part B Excess Charges Rider
- Outpatient Prescription Drug Rider
- Foreign Travel Rider

Insurance companies are allowed to offer additional riders to a Medigap plan.

MEDICARE PART A COVERAGE CHART

Medicare Part A (Hospital Insurance) Covers:	What You Pay in 2000* in the Original Medicare Plan
Hospital Stays: Semiprivate room, meals, general nursing and other hospital services and supplies. This does not include private duty nursing, a television or telephone in your room, or a private room, unless medically necessary. Inpatient mental health care coverage in a psychiatric facility is limited to 190 days in a lifetime.	**For each benefit period you pay:** • A total of $776 for a hospital stay of 1-60 days. • $194 per day for days 61-90 of a hospital stay. • $388 per day for days 91-150 of a hospital stay. (See Lifetime Reserve Days on page 102) • All costs for each day beyond 150 days.
Skilled Nursing Facility (SNF) Care:** Semiprivate room, meals, skilled nursing and rehabilitative services, and other services and supplies (after a 3-day hospital stay).	**For each benefit period you pay:** • Nothing for the first 20 days. • Up to $97 per day for days 21-100. • All costs beyond the 100th day in the benefit period. If you have questions about SNF care and conditions of coverage, call your Fiscal Intermediary.***
Home Health Care:** Part-time skilled nursing care, physical therapy, occupational therapy, speech-language therapy, home health aide services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers) and supplies, and other services.	**You pay:** • Nothing for home health care services. • 20% of approved amount for durable medical equipment. If you have questions about home health care and conditions of coverage, call your Regional Home Health Intermediary.***
Hospice Care:** Medical and support services from a Medicare-approved hospice, drugs for symptom control and pain relief, short-term respite care, care in a hospice facility, hospital, or nursing home when necessary, and other services not otherwise covered by Medicare. Home care is also covered.	**You pay:** • A copayment of up to $5 for outpatient prescription drugs and 5% of the Medicare payment amount for inpatient respite care (short-term care given to a hospice patient by another care giver, so that the usual care giver can rest). The amount you pay for respite care can change each year. If you have questions about hospice care and conditions of coverage, call your Regional Home Health Intermediary.***
Blood: Given at a hospital or skilled nursing facility during a covered stay.	**You pay:** • For the first 3 pints of blood if you do not replace it.

* New Part A and B amounts will be available by January 1, 2001.

** You must meet certain conditions in order for Medicare to cover these services.

*** Call 1-800-633-4227 to get the telephone number for the Fiscal Intermediary or Regional Home Health Intermediary in your state.

If you have general questions about Medicare Part A, call your Fiscal Intermediary.

MEDICARE PART B COVERAGE CHART

Medicare Part B (Medical Insurance) Covers:	What You Pay in 2000* in the Original Medicare Plan
Medical and Other Services: Doctors' services (except for routine physical exams), outpatient medical and surgical services and supplies, diagnostic tests, ambulatory surgery center facility fees for approved procedures, and durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers).	**You pay:** • $100 deductible (pay once per calendar year). • 20% of approved amount after the deductible, excep the outpatient setting.
Also covers outpatient physical and occupational therapy including speech-language therapy.	• 20% for all outpatient physical, occupational, and speech therapy services.
Outpatient mental health services.	• 50% for most outpatient mental health. **See note bel**
Clinical Laboratory Service: Blood tests, urinalysis, and more.	**You pay:** • Nothing for Medicare-approved services.
Home Health Care:** Part-time skilled care, home health aide services, durable medical equipment when supplied by a home health agency while getting Medicare covered home health care, and other supplies and services.	**You pay:** • Nothing for services. • 20% of approved amount for durable medical equipment.
Outpatient Hospital Services: Services for the diagnosis or treatment of an illness or injury.	**You pay:** • 20% of the charged amount (after the deductible). During the year 2000, this will change to a set copayment amount.
Blood: Pints of blood needed as an outpatient, or as part of a Part B covered service.	**You pay:** • For the first 3 pints of blood, then 20% of the approved amount for additional pints of blood (after the deductible) if you do not replace it.

* New Part A and B amounts will be available by January 1, 2001.

** You must meet certain conditions in order for Medicare to cover these services.

Note: Actual amounts you must pay are higher if the doctor does not accept assignment (see page 100). If you have general questions about your Medicare Part B coverage, call your Medicare Carrier (see pages 92-93).

MEDICARE PART B PREVENTIVE SERVICES CHART

Medicare Part B Covered Preventive Services	Who is covered...	What you pay...
Bone Mass Measurements: Varies with your health status.	Certain people with Medicare who are at risk for losing bone mass.	20% of the Medicare-approved amount after the yearly Part B deductible.
Colorectal Cancer Screening: • Fecal Occult Blood Test - Once every 12 months. • Flexible Sigmoidoscopy - Once every four years. • Colonoscopy - Once every two years if you are high risk for cancer of the colon. • Barium Enema - Doctor can substitute for sigmoidoscopy or colonoscopy.	All people with Medicare age 50 and older. However, there is no age limit for having a colonoscopy.	No coinsurance and no Part B deductible for the fecal occult blood test. For all other tests, 20% of the Medicare-approved amount after the yearly Part B deductible.
Diabetes Monitoring: Includes coverage for glucose monitors, test strips, lancets, and self-management training.	All people with Medicare who have diabetes (insulin users and non-users).	20% of the Medicare-approved amount after the yearly Part B deductible.
Mammogram Screening: Once every 12 months.	All women with Medicare age 40 and older.	20% of the Medicare-approved amount with no Part B deductible.
Pap Smear and Pelvic Examination: (Includes a clinical breast exam) Once every three years. Once every 12 months if you are high risk for cervical or vaginal cancer, or if you are of childbearing age and have had an abnormal Pap Smear in the preceding three years.	All women with Medicare.	No coinsurance and no Part B deductible for the Pap Smear (clinical laboratory charge). For doctor services and all other exams, 20% of the Medicare-approved amount with no Part B deductible.
Prostate Cancer Screening: • Digital Rectal Examination - Once every 12 months. • Prostate Specific Antigen (PSA) Test - Once every 12 months.	All men with Medicare age 50 and older.	Generally, 20% of the Medicare-approved amount after the yearly Part B deductible. No coinsurance and no Part B deductible for the PSA Test.
Shots (Vaccinations): • Flu Shot - Once every 12 months. • Pneumonia Shot - One may be all you ever need, ask your doctor. • Hepatitis B Shot - If you are at medium to high risk for hepatitis.	All people with Medicare.	No coinsurance and no Part B deductible for flu and pneumonia shots if the doctor accepts assignment (see page 100). For Hepatitis B shots, 20% of the Medicare-approved amount after the Part B deductible.

* ACTIVITIES OF DAILY LIVING (ADL): Activities you usually do during a normal day. Although definitions differ, ADL's are usually viewed as everyday activities such as walking, getting in and out of bed, dressing, bathing, eating, and using the bathroom.

ASSIGNMENT: In the Original Medicare Plan, a process in which a doctor or supplier agrees to accept the amount Medicare approves as full payment. You must pay any coinsurance amount.

BASIC (CORE) BENEFITS: Benefits provided in Medigap Plan A. They are also included in all the other Medigap plans.

BENEFIT PERIOD: The way that Medicare measures your use of hospital and skilled nursing facility services. A benefit period starts the day you go to a hospital or skilled nursing facility. The benefit period ends when you haven't received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after 60 days, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

BENEFITS: The money or services provided by an insurance policy. In a health plan, benefits are the health care you get.

COINSURANCE: The percent of the Medicare-approved amount that you have to pay after you pay the deductible for Part A and/or Part B. In the Original Medicare Plan, the coinsurance payment is a percentage of the approved amount for the service (like 20%).

* CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA) OF 1985: COBRA is a law that requires employers with 20 or more employees to let employees and their dependents keep their group health plan coverage for a period of time after they leave their group health plan under certain conditions. You may have to pay both your share and the employer's share of the premium.

COORDINATION OF BENEFITS CLAUSE: A written statement that tells which health plan or insurance policy pays first if two health plans or insurance policies cover the same benefits. If one of the plans is Medicare, federal law may decide who pays first.

COPAYMENT: In some Medicare health plans, the amount you pay for each medical service, like a doctor visit. A copayment is usually a set amount you pay for a service. For example, this could be $5 or $10 for a doctor visit. Copayments may also be used for hospital outpatient services in the Original Medicare Plan later this year.

* This definition, whole or in part, was used with permission from Walter Feldesman, Esq., Dictionary of Eldercare Terminology, 2000.

CREDITABLE COVERAGE: Any previous health coverage that can be used to shorten the pre-existing condition waiting period. (See pre-existing conditions.)

CUSTODIAL CARE: Personal care, such as bathing, cooking, and shopping. This is usually not covered by Medicare.

DEDUCTIBLE (MEDICARE): The amount you must pay for health care before Medicare begins to pay, either each benefit period for Part A, or each year for Part B. These amounts can change every year. (see Benefit Period; Part A; Part B)

DURABLE MEDICAL EQUIPMENT (DME): Medical equipment that is ordered by a doctor for use in the home. These items must be reusable, such as walkers, wheelchairs, or hospital beds. DME is paid for under Medicare Part B, and you pay 20% coinsurance in the Original Medicare Plan.

* END-STAGE RENAL DISEASE (ESRD): Kidney failure that is severe enough to require lifetime dialysis or a kidney transplant. ESRD patients are eligible for Social Security payments if found to be disabled.

* EXCESS CHARGE (MEDIGAP): The difference between a doctor's or other health care provider's actual charge (which may be limited by Medicare or the state) and the Medicare-approved payment amount.

FISCAL INTERMEDIARY: A private company that has a contract with Medicare to pay Part A and some Part B bills. (Also called "Intermediary.")

GAPS: The costs or services that are not covered under the Original Medicare Plan. Also called Medicare gaps.

GUARANTEED ISSUE SITUATIONS: Certain situations involving health coverage changes where you may have the right to buy a Medigap policy in addition to your Medigap open enrollment period.

GUARANTEED RENEWABLE: A Medigap policy that your insurance company must allow you to automatically renew or continue, unless you do not pay your premiums.

HEALTH CARE FINANCING ADMINISTRATION (HCFA): The federal agency that runs the Medicare program. In addition, HCFA works with the States to run the Medicaid and State Children's Health Insurance Program. HCFA works to make sure that the beneficiaries in these programs are able to get high quality health care.

HOME HEALTH CARE: Skilled nursing care and certain other health care you get in your home for the treatment of an illness or injury. (See Activities of Daily Living.)

* This definition, whole or in part, was used with permission from Walter Feldesman, Esq., Dictionary of Eldercare Terminology, 2000.

LIFETIME RESERVE DAYS: Sixty days that Medicare will pay for when you are in a hospital for more than 90 days. These 60 reserve days can be used only once during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance ($388 in 2000).

LIMITING CHARGE: The highest amount of money you can be charged for a covered service by doctors and other health care providers who don't accept assignment. The limit is 15% over Medicare's approved amount. The limiting charge only applies to certain services and does not apply to supplies and equipment.

LONG-TERM CARE: Custodial care given at home or in a nursing home for people with chronic disabilities and lengthy illnesses. Long-term care is not covered by Medicare.

MEDICAID: A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

MEDICAL UNDERWRITING: The process that an insurance company uses to decide whether or not to take your application for insurance, whether or not to add a waiting period for pre-existing conditions (if your state law allows it), and how much to charge you for that insurance.

MEDICARE: A federal health insurance program for: people 65 years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant, sometimes called ESRD).

MEDICARE CARRIER: A private company that contracts with Medicare to pay Part B bills. (Also called "Carrier.")

MEDICARE COVERAGE: Made up of two parts: Hospital Insurance (Part A) and Medical Insurance (Part B).

MEDICARE PART A (HOSPITAL INSURANCE): Hospital insurance that pays for inpatient hospital stays, care in a skilled nursing facility, home health care, and hospice care.

MEDICARE PART B (MEDICAL INSURANCE): Medical insurance that helps pay for doctors' services, outpatient hospital care, and other medical services that are not covered by Part A.

MEDICARE SELECT: A type of Medigap policy that may require you to use doctors and hospitals within its network to be eligible for full benefits.

MEDIGAP: A Medicare supplemental health insurance policy sold by private insurance companies to fill "gaps" in Original Medicare Plan coverage. Except in Minnesota, Massachusetts, and Wisconsin, there are 10 standardized policies labeled Plan A through Plan J. Medigap policies only work with the Original Medicare Plan. (See Gaps.)

MEDIGAP PROTECTIONS: Your rights to buy a Medigap policy in certain situations after your Medigap open enrollment period.

OPEN ENROLLMENT PERIOD (MEDIGAP): A one-time only, six month period after you enroll in Medicare Part B and are age 65 or older, when you can buy any Medigap policy you want. You cannot be denied coverage or charged more due to your health history during this time.

ORIGINAL MEDICARE PLAN: A pay-per-visit health plan that lets you go to any doctor, hospital, or other health care provider who accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance). The Original Medicare Plan has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance).

OUT-OF-POCKET COSTS: Health care costs that you must pay on your own, because they are not covered by Medicare or other insurance.

PRE-EXISTING CONDITION (MEDIGAP): A health problem for which you got medical treatment or advice within 6 months before the date that a new insurance policy starts.

PREMIUM: The periodic payment to Medicare, an insurance company, or health care plan for health care coverage.

PREVENTIVE CARE: Care to keep you healthy or to prevent illness, such as colorectal cancer screening, yearly mammograms, and flu shots.

PRIMARY PAYER: The insurance company that pays first on a claim for medical care. This could be Medicare or another insurance company.

PROVIDER: A hospital, health care professional, or health care facility.

SECONDARY PAYER: The insurance company that pays second on a claim for medical care. This could be Medicare, Medicaid, or other health insurance depending on the situation.

SKILLED NURSING FACILITY (SNF): A facility that provides skilled nursing or rehabilitation services to help you recover after a hospital stay.

WAITING PERIOD: The time between when you sign up with a Medigap insurance company or Medicare health plan and when the coverage starts.

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U.S. DEPARTMENT OF
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Health Care Financing Administration
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To get this *2000 Guide to Health Insurance for People with Medicare* on audio-tape, in large type, or in braille, call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired).

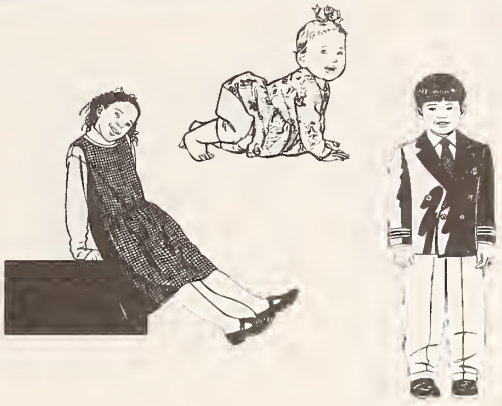
¿Necesita usted una copia en Español o en audio-cassette del manual de *La Guía de Seguro de Salud para personas con Medicare*? (Llame al 1-800-633-4227.)

2000 Guide to Health Insurance for People With Medicare

New Health Insurance Is Now Available For:

- ✔ Infants
- ✔ Children
- ✔ Teens

Your children or grandchildren may qualify for free or low-cost health insurance.



Does your family have health insurance? There is a new program that can help working and non-working families get health insurance for their children (ages 0-19).

Health insurance helps pay for:

- Check-ups.
- Shots that protect children from some illnesses.
- Health care for illnesses and injuries.

Don't put it off . . .
tomorrow could be the day your children or grandchildren need insurance most.

For more information visit www.insurekidsnow.gov or call:

1-877-KIDS-NOW

(1-877-543-7669)

This is a free call.

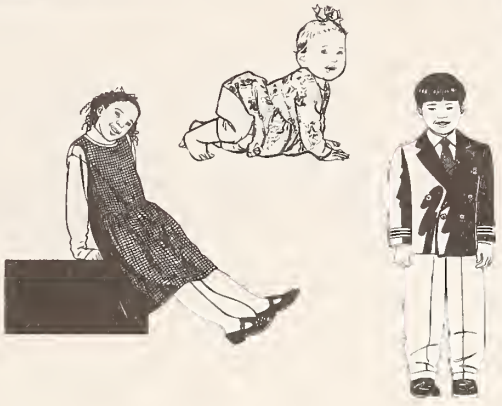
HCFA
MEDICARE • MEDICAID
Health Care Financing Administration

Publication No. HCFA–10135

Nuevo Seguro de Salud Disponible Ahora para:

- ✔ Infantes
- ✔ Niños
- ✔ Adolescentes

Sus hijos o nietos podrán calificar para recibir seguro de salud gratis o de bajo costo.



¿Dispone su familia de seguro de salud? Hay un nuevo programa que ofrece ayuda a familias con o sin trabajo para obtener seguro de salud para sus hijos (de hasta 19 años de edad).

El seguro de salud paga por:

- Chequeos.
- Inyecciones que protejen a los niños contra enfermedades.
- Cuidado de salud para enfermedades o lesiones.

No ignore esta oportunidad. . .
mañana puede ser el día en que sus hijos y nietos necesiten más el seguro.

Si desea más información visite www.insurekidsnow.gov o llame al:

1-877-KIDS-NOW

(1-877-543-7669)

Esta llamada es gratis.

HCFA
MEDICARE · MEDICAID
Health Care Financing Administration

Publication No. HCFA–10135

your guide to

Choosing a Nursing Home

THIS BOOKLET EXPLAINS...

- Key Issues.
- Alternatives to Nursing Homes.
- Important Selection Factors.
- Nursing Home Resident Rights.
- Nursing Home Checklist.
- Sources of Help and Information.

Health Care Financing Administration
The Federal Medicare Agency

READER NOTICE

The Health Care Financing Administration (HCFA) is the Federal Agency that oversees Medicare and Medicaid. Because most nursing home care is financed by Medicare or Medicaid, HCFA has to make sure nursing homes provide good care to residents. HCFA has a nursing home initiative which focuses on assuring quality care. This initiative has three parts: education, empowerment, and enforcement which are described below. This publication is designed to educate the reader about some important issues in nursing home care.

EDUCATION

Physical or chemical restraints on residents should be limited to circumstances where the resident's medical symptoms warrant them.

Residents must have enough of the right food and fluids to be healthy.

Resident abuse and neglect must not be tolerated.

EMPOWERMENT

Read admission agreements carefully and know your resident rights under Federal law.

Do not make a pre-payment or a cash deposit just to get into a nursing home if your care will be covered by Medicare or Medicaid.

Do not give up the right to apply for Medicare or Medicaid benefits or give up any transfer or discharge rights you may have.

ENFORCEMENT

When you see this symbol (☎), look in the back of this publication for the telephone number of agencies that work with HCFA to assure quality nursing home care. They can help you with questions or concerns you may have about nursing home care.

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INTRODUCTION

A nursing home is a residence that provides a room, meals, skilled nursing and rehabilitative care, medical services, and protective supervision to residents. It also provides residents with help with daily living and recreational activities. Many nursing home residents have physical, emotional or mental impairments which keep them from living independently. Nursing homes are certified by State and Federal government agencies to provide levels of care which range from custodial care to skilled nursing care that can only be delivered by trained professionals.

On any given day, nursing homes care for about one in twenty Americans over the age of 65.

Selecting a nursing home is one of the most important decisions that you may be asked to make. Depending on where you live, there may not be many choices in selecting a nursing home. This booklet outlines a step-by-step process that will help you compare nursing homes and make the best possible choice. This booklet also lists some key resources that will help you find the nursing home or long-term care facility that fits your needs.

If you must select a nursing home with little notice—during a family crisis or right after a serious illness, this publication should still give you valuable information about nursing homes and about the people who are able to help you if you have any concerns.

This publication is not a legal document. The official provisions of the Medicare and Medicaid programs are contained in the relevant laws, regulations, and rulings.

TALK TO PEOPLE #1

Before you begin to search for a nursing home, talk with people you trust and who can help you make a good choice. This group could include family and friends. It also could include a variety of health professionals like doctors, dietitians, social workers, and hospital discharge planners, who understand your special needs. Discuss your care needs and options with your group. They may be willing to help you.

The likelihood of being a resident of a certified nursing home increases with age.

If you are helping someone who is about to go into a nursing home, get them involved as much as possible. His or her wishes need to be respected. People who are involved from the beginning are better prepared when they move into a nursing home. If the person you are helping is not alert or able to communicate well, keep his or her values and preferences in mind. Finding a nursing home that provides the right services in a pleasant, comfortable atmosphere often requires work.

Ideally, you will have enough time to plan ahead, examine several nursing homes, and make good financial plans. Planning ahead gives you more control over the selection process, eases the stress of choosing a nursing home, and helps you make a good choice.

#2 LOOK AT OPTIONS

In most communities, people who cannot live independently may choose from a variety of living arrangements that offer different levels of care. Before deciding on a care setting, talk to a doctor or maybe a social worker about your care needs. Most people want to stay in their home for as long as possible. However, if you are considering staying at home, make sure you know the amount of responsibility and work involved. If you cannot live independently, but don't want to live in a nursing home, you may want to consider some of the alternatives listed below.

The Elder Care Locator can help you find necessary and convenient services that serve the elderly in their community. 1–800–677–1116

Home and Community Care

A person who is ill or disabled may be able to get help from a variety of home services that might make moving into a nursing home unnecessary. Home services include Meals on Wheels programs, friendly visiting and shopper services, and adult day care. These programs are found in most communities.

If you are considering home care, discuss this option with family members to learn if they are able to help provide your care or help arrange for other care providers to come to your home. Some nursing homes may provide respite care and admit a person in need of care for a short period of time to give the home care givers a break.

Depending on the case, Medicare, private insurance, and Medicaid may pay some home care costs that are related to medical care.

Subsidized Senior Housing (Non-Medical)

There are Federal and State programs that help pay for housing for older people with low to moderate

incomes. Some of these subsidized facilities offer assistance to residents who need help with certain tasks, such as shopping and laundry. Residents generally live independently in an apartment within the senior housing complex.

Assisted Living (Non-Medical Senior Housing)

If you only need help with a small number of tasks, such as cooking and laundry, or reminders to take medications, assisted living facilities may be an option worth considering. "Assisted living" is a general term for living arrangements in which some services are available to residents who still live independently within the assisted living complex. In most cases, assisted living residents pay a regular monthly rent, and then pay additional fees for the services that they require.

Usually, payment for assisted living care is not subsidized by other programs.

Board and Care Homes

Board and Care homes are group living arrangements designed to meet the needs of people who cannot live independently, but do not require nursing home services. These homes offer a wider range of services than independent living options. Most provide help with some of the activities of daily living, including eating, walking, bathing, and toileting. In some cases, private long-term care insurance and medical assistance programs will help pay for this type of living arrangement. Keep in mind that many of these homes do not get payment from Medicare or Medicaid and are not strictly monitored.

Continuing Care Retirement Communities (CCRCs)

CCRCs are housing communities that provide different levels of care based on the residents' needs from independent living apartments to skilled nursing care in an affiliated nursing home. Residents move from one setting to another based on their needs, but continue to remain a part of their CCRC community. Be sure to check the record of the CCRC's nursing home. Your CCRC contract usually will require you to use it. Many CCRCs require a large payment prior to admission and also charge monthly fees. For this reason, many CCRCs may be too expensive for older people with modest incomes.

Tip

Talk with people you trust before you make a decision about the type of care you may want.

Summary of Options

The options discussed in this chapter may work for people who require less than skilled care, or who require skilled care for only brief periods of time. Many people with long-term skilled care needs require a level and amount of care that cannot be easily handled outside of a nursing home.

GATHER INFORMATION #3

If you decide that a nursing home is the right choice, begin to gather information about the nursing homes in an area near your family and friends. The first step is to talk with your doctor or other health providers for suggestions. Then, look in the phone book. Your yellow pages list local nursing homes. Word of mouth can be a good source of information. Ask your friends and neighbors if they know people who have lived in local nursing homes. Also, your State or county Office on Aging (in the blue pages of your phone book) should have a listing of nursing homes in your area.

In 1999, there were about 16,000 certified nursing homes in the U.S. . . .

and1.5 million people were living in them.

Nationwide, there are more than 600 Long-Term Care Ombudsman programs. They are a very good source of information and can be an important resource to nursing home residents, their families, and friends. Ombudsman volunteers visit nursing homes on a regular basis. They can provide information about how homes are organized and regulated. Ombudsmen should know about the strengths and weaknesses of nursing homes in their area. They can work to resolve problems such as poor care, dietary needs, and financial issues. Ombudsmen also can help you determine how problems in nursing homes can be best handled. (☎)

Although Ombudsman programs are not allowed to recommend one nursing home over another, they can provide the results of the latest State inspection on the home and some information about the nursing home's complaint history. Nursing home inspections are discussed in Chapter 6. Ombudsman programs can help explain any information that is not clear and

can give general advice on what to look for when visiting the various area nursing homes. (☎)

Another good source of information is the new Nursing Home Compare database at Medicare's Internet website **www.medicare.gov**. It gives you information about every Medicare and Medicaid certified nursing home in the country and the results from their latest nursing home inspection. You can search for nursing homes by geographic area and get a side-by-side comparison of important information like quality of care (bed or pressure sores are an example). The information is in an easy to read chart format. If you do not have a computer, your local library or senior center may be able to help you access the Internet.

EVALUATE FACTORS

#4

The next step is to call the nursing homes on your list. Ask about the following factors. They are **very important** and can narrow your list of nursing homes.

Location

Location is very important. If you choose a nursing home that is close to your family and friends, they may be able to visit you more often, and you may feel less lonely. Also, they can act as your advocate (supporter) if you need one.

Availability

Nursing homes have a limited number of beds. When you find a nursing home you like, you should find out if there will be a bed available for you or if you can add your name to a waiting list. Although nursing homes do not have to accept all applicants for admission, they do have to comply with Civil Rights provisions that prohibit discrimination based on race, religion, etc.

On average, 8 out of 10 beds in certified nursing homes are occupied.

Staffing

It is important that the people who work in a nursing home are capable of performing their duties. This helps make sure that the residents are cared for and enjoy a good quality of life. Chapter 7 and the Check List in this publication have more detailed information.

Medicare and Medicaid

If you will be using Medicare or Medicaid to pay for your care, make certain that the nursing homes on your list accept Medicare or Medicaid payment. Often, a facility will set aside only a few beds for Medicare or Medicaid residents. Find out if the home will have

In 1996, nursing home expenditures were about $78.5 billion.

Medicare or Medicaid "beds" available when you need one. This is particularly important for people who change from paying privately to Medicaid during the course of their stay at a nursing home. When this happens, if "Medicaid" beds are not available, you may have to transfer to another facility. Even when Medicaid certified beds are available, under current law, a nursing home does not have to give one to a resident.

Services and Fees

The nursing home must inform you, in writing, about its services, charges, and fees before you enter the home. Most facilities charge a basic rate that covers room, meals, housekeeping, linen, general nursing care, recreation, and some personal care services. There may be extra charges for personal services, such as haircuts, manicures, and telephones. Get a copy of the fee schedule in advance so you can compare them with other homes.

Medicare beneficiaries pay coinsurance amounts and other charges for personal services when they become due. They do not pay before the service is given.

Religious and Cultural Preferences

Do the nursing homes on your list offer the type of religious and cultural environment that you prefer, including any special diets your faith practice may require?

Language

Do the staff and many of the residents speak your primary language? If not, you may not be able to communicate your needs and may feel lonely in the environment.

Special Care Needs

Are the nursing homes on your list able to provide care for any special medical condition you may need? Examples of medical conditions are dementia, End-Stage Renal Disease (ESRD), or Alzheimers.

#5 PAYING FOR CARE

For most people, finding ways to pay for nursing home care is a major concern because it is so expensive. There are several payment methods to consider.

Medicare

Under certain limited conditions, Medicare will pay some nursing home costs for Medicare beneficiaries who require skilled nursing or rehabilitation services. To be covered, you must receive the services from a Medicare certified skilled nursing home after a qualifying hospital stay. A qualifying hospital stay is the amount of time spent in a hospital just prior to entering a nursing home. This is at least three days. To learn more about Medicare payment for skilled nursing home costs, contact your Medicare Fiscal Intermediary or the State Health Insurance Assistance Program (SHIP) in your State. (☎)

Medicaid is the primary payer for about 7 out of 10 nursing home residents.

Medicaid

Medicaid is a State and Federal program that will pay most nursing home costs for people with limited income and assets. Eligibility varies by State. Check your State's requirements to learn if you are eligible. Medicaid will pay only for nursing home care provided in a facility certified by the government to provide service to Medicaid recipients. For more information about Medicaid payments, call the SHIP for your State (☎) or call your State's Medicaid office. The telephone number is in the blue pages of the phone book.

In 1996, private payments for nursing home care were about $30.2 billion.

Personal Resources

About half of all nursing home residents pay nursing home costs out of their own savings. After these

savings and other resources are spent, many people who stay in nursing homes for long periods eventually become eligible for Medicaid.

Managed Care Plans

A managed care plan will not help pay for care unless the nursing home has a contract with the plan. If the home is approved by your plan, learn if the plan also monitors the home for quality of nursing care.

Medicare Supplemental Insurance

This is private insurance. It's often called Medigap because it helps pay for gaps in Medicare coverage such as deductibles and co-insurances. Most Medigap plans will help pay for skilled nursing care, but only when that care is covered by Medicare. Some people use employer group health plans or long-term care insurance to help cover nursing home costs.

Long-Term Care Insurance

This is a private policy. The benefits and costs of these plans vary widely. For more information on these plans, contact the National Association of Insurance Commissioners (NAIC). It represents state health insurance regulators and has a free publication called A Shopper's Guide to Long-Term Care Insurance. You also can get a copy of the Guide to Health Insurance for People with Medicare by calling 1-800-MEDICARE.

Counseling and Assistance

SHIPs (☎) have counselors who might be able to answer your questions about how to pay for nursing home care, the coverage you may already have, or whether there are any government programs that will help with your expenses.

Write to the NAIC:
Publications
Department
120 West 12th Street
Suite 1100
Kansas City, MO
64105

The number for the Medicare toll free line is 1-800-633-4227.

If you use a TTY/TDD line, the telephone number is 1-877-486-2048.

#6 VISIT NURSING HOMES

The nursing home visit is a very important step in selecting the right nursing home for you. A visit gives you an opportunity to talk with nursing home staff and, more importantly, with the people who live and receive care at the nursing home.

When you visit the nursing home, you will probably be given a formal tour. This is a useful introduction to the home, but it is important that you are not overly influenced by a guided tour. Use this time to evaluate the overall atmosphere of the home.

Tip

The Check List at the end of this publication will give you some more ideas on questions to ask.

When the tour is over, tell the nursing home staff you may want to return, but don't want another formal tour. Get some suggestions of different times of the week and day to visit. This should give you a complete picture of the services and activities available to residents. When you return, make sure to check with nursing home staff before entering resident care areas. Respect resident privacy when walking around.

The Nursing Home Inspection

Near the end of your visit, ask to see a copy of the nursing home's most recent inspection. An inspection is a written report that says how well the nursing home meets Federal health and safety requirements. This report is like a snapshot. It shows what deficiencies were found at the time of the inspection. Deficiencies are rated on scope and severity. Scope tells you how often a certain problem occurs. Severity tells you how seriously the problem impacts the health and safety of residents.

Tip

See Nursing Home Compare at www.medicare.gov for help.

Nursing homes are inspected about every nine to fifteen months. Usually this is done by employees of the State where the nursing home is located. Nursing

homes that do not meet State and Federal requirements are subject to fines and other penalties if their deficiencies are not corrected. By law, the nursing home inspection report must be posted in an area that is convenient for residents and their visitors to see. (☎)

Quality of Life

The law requires that residents receive the necessary care and services that will enable them to reach and maintain their highest practicable level of physical, mental, and social well-being. In the last decade, different laws and regulations also have been passed to raise the quality of life and standards of care for nursing home residents.

Nursing home residents rate the way they are treated by staff as an important factor in their happiness.

When considering a nursing home, it is important to remember that people who are admitted into nursing homes do not leave their personalities at the door. They keep life-long preferences and habits. They still have the basic human need for respect, encouragement, and friendship.

To maintain a good quality of life, nursing home residents:

- Need to keep as much control over the events in their daily lives as possible. People can become very depressed when these basic decisions are made by others or life-long patterns are changed.
- Should have the freedom and privacy to attend to their personal needs, to participate in their care planning, and to examine their medical records.

- May only be restrained to treat medical symptoms if using them is reflected in the resident's comprehensive assessment and care plan. Benefits from using restraints should outweigh the risks of harm to the resident.

When you visit a nursing home, keep these questions in mind.

Tip

Use the tips in the Quality of Life section of the Check List to help you evaluate the nursing home.

- Does the interaction between residents and the staff seem warm and friendly?
- Most residents must share their room. Do residents have a reasonable choice of roommates? How are differences between roommates resolved?
- Even though space in nursing homes is limited, having a few cherished items can be very comforting. How does the home help protect resident's property and personal items?
- Does the nursing home provide a variety of activities that residents like and allow residents to choose the activities they want to attend? Are there activities for bed-bound patients?
- Are family members encouraged to visit, and are they encouraged to bring special ethnic or religious foods on special or holy days?

Quality of Care

By law, nursing homes must make a thorough assessment of every new resident within two weeks of admission. The assessment covers important issues like the resident's mobility, skin condition, nutritional

and medical status, rehabilitation needs, and daily habits.

Based upon the assessment, the home also must complete a resident care plan that helps each resident reach or keep his or her highest level of well-being. Good care plans are put together by a variety of health care providers as well as the resident, and family and friends. Care plans may change as a resident's needs change.

Tip

Care plan meetings should be held at times when it is easy for family and friends to attend.

Unless you have a medical or social work background, it might be difficult to assess the quality of health care the nursing home provides to its residents. However, that does not mean you cannot trust your senses: does the home look and smell clean, is it pleasantly lit, do residents seem relaxed, and do staff seem to respond quickly to call lights for help?

Other ways to evaluate the home are:

- Check the most recent State inspection report. If the home was cited for deficient practices in any quality of care areas, ask staff how they were corrected. (☎)
- Learn if the home has written policies to prevent resident abuse and neglect.
- Does there seem to be enough staff to care for the number of residents.
- Find out how long the current staff have been working at the home.
- If you have special needs (dementia, permanent kidney disease, ventilator dependency), make sure the home has experience in working with people who have had the same condition.

Tip

See Nursing Home Compare at www.medicare.gov for help.

#7 FOLLOW-UP VISITS

You should visit the nursing homes on your list as many additional times as you think necessary. Make sure that you see the home at least once in the evening and on a weekend because staffing and care giving is frequently different at these times. You may want to take the time to get a copy of the nursing home's admission or contract agreements.

Every nursing home should have an admission contract or agreement. Read them carefully. They should not have any statements that make residents give up their rights. Resident rights are described in Chapter 8.

Tip

Resident and family councils must be free to act independently from the nursing home's management.

Also, it would be helpful if your follow-up visit included attending a meeting of the nursing home's resident council or family council. Resident and family councils play an active role in promoting quality of life for nursing home residents. Ask if you may attend a meeting or read the minutes from a meeting. They could give you a point of view from the nursing home staff and a closer look at the concerns of the residents or their families.

After your follow-up visits, if it is still difficult to decide upon a nursing home, call the Ombudsman (☎) and the other people who provided you with information and help in the past. If you have any additional questions, do not hesitate to contact or visit the nursing home again.

It is possible that more than one nursing home will be a good choice, but you now should have enough information to be confident that you are making a well-informed choice.

AFTER ADMISSION #8

New nursing home residents may go through a difficult adjustment period, even if the nursing home is doing all that it can. The adjustment can be made easier with the support of family and friends. The adjustment also can be made easier by knowing about your resident rights and some special protections under the law.

Respect

Nursing home residents have the right to be treated with dignity and respect. As long as it fits your plan of care, you have the right to make your own schedule, including when you go to bed, rise in the morning, and eat your meals. You have the right to select the activities you would like to attend. You also may have the right to leave the facility with relatives or friends after notifying the staff.

Restraints

It is against the law for a nursing home to use physical and chemical restraints, except when necessary, to treat medical symptoms. Restraints may not be used for discipline or for the convenience of the nursing home staff.

Restrained residents may have decreased functional ability, lower self-esteem and feel depressed or angry. Restraints do not provide security or safety. Residents also are likely to be seriously injured if they fall with a restraint on. A physician must provide medical orders for any use of restraints and give the reason why they are needed except in certain emergency circumstances.

Tip

Set up a filing system to keep track of papers and information about residents' rights, admission and transfer policies, and any other information the home provides.

Managing Money

You have the right to manage your own money or to pick someone you trust to do so. If you request the nursing home to manage your personal funds, you must sign a written statement that authorizes the nursing home to do this for you. However, the nursing home must allow you access to your bank accounts, cash, and other financial records. The nursing home must protect your funds from any loss by purchasing a bond or providing other similar assurances.

Tip

Try to extend homeowner or other policies to include resident's belongings.

Privacy, Property, and Living Arrangements

You have the right to privacy. In addition, you have the right to keep and use your personal property, as long as it does not interfere with the rights, health or safety of others. Your mail should never be opened by the home unless you allow it. The nursing home must have a system in place to keep you safe from neglect and abuse, and to protect your property from theft. See if there is a safe in the facility or cupboards with locked doors in resident rooms. If you and your spouse live in the same home, you are entitled to share a room (if you both agree to do so).

Tip

Make an inventory of things you bring into the home (including eyeglasses and dentures). Update it regularly.

Guardianship and Advance Directives

As a nursing home resident, you are responsible for making your own decisions (unless you are mentally unable or have made legal arrangements for help). You may also draw up a document called an Advance Directive. This sometimes is called a living will because it becomes effective while you are still alive. It is a legal document that says what type of treat-

ment you want or don't want in case you cannot speak for yourself.

If you wish, you may designate someone else to make health care decisions for you. This is called a Durable Power of Attorney for health care. The person you name will become your legal guardian if you ever become incapable of making your own decisions. Depending upon your State's laws, you may need a lawyer to draw up a Durable Power of Attorney order or a living will. Although the nursing home should be able to help you with this, other help is available.

Check with your State Health Insurance Assistance Program (SHIP) (☎) or with the local Office on Aging to find out if your State has any legal assistance services that help with preparing these documents. You will find the phone number for your local Office on Aging in the blue pages of your phone directory.

Visitors

You have the right to spend private time with visitors at any reasonable hour. You have the right to make and receive telephone calls in privacy. The nursing home must permit your family to visit you at any time, as long as you wish to see them. You do not have to see any visitor you do not wish to see. Any person who provides you with health or legal services may see you at any reasonable times.

Medical Care

You have the right to be informed about your medical condition, medications, and to participate in developing your Plan of Care. You have the right to examine your medical records and reports upon request. You

Tip

Get a copy of the care plan and the name of the staff who helped create it.

have the right to refuse medications or treatments, and to see your own doctor.

Social Services

The nursing home must provide each resident with any needed social services, including counseling, mediation of disputes with other residents, assistance in contacting legal and financial professionals, and discharge planning.

Moving Out

Living in a nursing home is voluntary. You are free to move to another place. However, nursing home admission policies usually require that you give proper notice that you are leaving. If you do not give proper notice, you may owe the nursing home money based on the home's proper notice rules. If you are going to another nursing home, make sure the home has a bed for you.

Discharge and Transfer

Whether leaving a room or the nursing home, change can be very traumatic for residents. Nursing homes cannot discharge you unless:

- It is necessary for the welfare, health, or safety of you or others;
- Your health has declined to the point that the nursing home cannot meet your care needs;
- Your health has improved to the point that nursing home care is no longer necessary;

- The nursing home has not been paid for services you received; or
- The nursing home closed.

Except in emergencies, the facility must give a 30 day written notice of discharge or transfer. Residents have the right to appeal a transfer to another facility.

Rights for Families and Friends

Relatives and friends have rights too. Family members and legal guardians have the right to privacy when visiting the nursing home when the resident asks. They also have the right to meet with the families of other residents and to join or address family councils.

By law, nursing homes must develop a plan of care for every resident. Family members are allowed to participate in the development of the care plan with the resident's permission. Relatives who have legal guardianship of nursing home residents have the right to examine all medical records concerning their loved one and the right to make important decisions on his or her behalf.

Family and friends can make sure the resident receives good care. They visit often, know the nursing home's staff and procedures, express concerns to the right staff member, and are active in the nursing home's family council.

Although there are people in the nursing home who may be able to help, if the home does not address your concerns or complaints, call the State's inspection agency or the Long-Term Care Ombudsman. (☎)

Tip

Your local Long-Term Care Ombudsman program can help with any concerns or questions you have about nursing homes. ☎

Family and resident councils provide a strong unified voice for resident concerns.

IMPORTANT NUMBERS

The programs and agencies listed below can help you. Call the Long-Term Care Ombudsman to get help with a complaint about quality of care or life in a nursing home and to get help in mediating a dispute with a nursing home. Call the State to get information about the latest State inspection on nursing homes or to file a complaint against a nursing home. Call the State Health Insurance Assistance Program (SHIP) to get general information about Medicare benefits and programs.

Calls made to the toll free numbers should be free when made within the respective State. The telephone numbers in this section were correct when published. Check the Internet (www.medicare.gov) for current telephone numbers.

State	Long-Term Care Ombudsman	State Survey Agency	State Health Insurance Assistance Program
Alabama	1-334-242-5743 1-800-243-5463	1-334-206-5075 1-800-356-9596 * 1-800-855-1155 TDD	1-334-242-5743 1-800-243-5463 * 1-334-242-0995 TDD
Alaska	1-907-563-6393 1-800-730-6393 *	1-907-561-8081	1-907-269-3680 1-800-478-9996 *
American Samoa	1-808-586-0100 1-800-999-4454	1-808-692-7420 1-800-468-4644 * 1-800-586-4648 TDD	1-808-586-7299
Arizona	1-602-542-4446 1-800-432-4040 1-602-542-6435 TDD	1-602-674-9705	1-602-542-6595 1-800-432-4040 1-602-542-6366 TDD
Arkansas	1-501-682-2441 1-501-682-2443 TDD	1-501-661-2000 1-800-482-5400 1-501-661-2328 TDD	1-501-371-2782 1-800-224-6330

* In-state only

State	Long-Term Care Ombudsman	State Survey Agency	State Health Insurance Assistance Program
California	1-916-323-6681 1-800-231-4024	1-916-445-2070 1-800-236-9747 1-800-735-2929 TDD	1-916-323-7315 1-800-434-0222 1-800-735-2929 TDD
Colorado	1-303-722-0300 1-800-288-1376	1-303-692-2800 1-808-886-7689 *	1-303-894-7499 ext. 356 1-800-544-9181 1-303-894-2900 ext. 833 TDD
Connecticut	1-860-424-5200	1-860-509-7400 1-860-509-7191 TDD	1-860-424-5245 1-800-994-9422 * 1-860-842-5424 TDD
Delaware	1-302-577-4791 1-800-223-9074	1-302-577-6666	1-302-739-6266 1-800-336-9500 *
District of Columbia	1-202-434-2190	1-202-442-5888	1-202-676-3900
Florida	1-850-488-6190 1-800-511-7023	1-850-488-1295	1-850-414-2060 1-800-963-5337 * 1-850-414-2001 TDD
Georgia	1-404-657-5334 1-800-669-8387	1-404-657-5850	1-404-657-5334 1-800-669-8387 *
Guam	1-808-586-0100 1-800-999-4454 *	1-671-475-0262	1-808-586-7299

* In-state only

State	Long-Term Care Ombudsman	State Survey Agency	State Health Insurance Assistance Program
Hawaii	1-808-586-0100 1-800-999-4454 *	1-808-692-7420 1-800-468-4644 *	1-808-586-7299
Idaho	1-208-334-4693	1-208-334-6626	1-208-334-4350 1-800-247-4422 * 1-800-377-3529 TDD
Illinois	1-217-524-6911 1-800-252-8966 *	1-217-782-5180 1-800-252-4343 *	1-217-785-9021 1-800-548-9034 * 1-217-524-4872 TDD
Indiana	1-317-232-7134 1-800-545-7763	1-317-233-7442 1-800-246-8909	1-317-233-3475 1-800-452-4800
Iowa	1-515-281-5426 1-800-532-3213 * 1-515-281-5188 TDD	1-515-281-4115 1-515-242-6515 TDD	1-515-281-6867 1-800-351-4664
Kansas	1-785-296-3017 1-877-662-8362	1-785-296-1240 1-800-842-0078 *	1-316-337-7386 1-800-860-5260 * 1-877-235-3151 TDD
Kentucky	1-502-564-6930 1-800-372-2991 1-888-642-1137 TDD	1-502-564-2800	1-502-564-7372 1-502-564-0126 TDD
Louisiana	1-225-342-7100	1-225-342-0148	1-225-342-0825 1-800-259-5301 *
Maine	1-207-621-1079 1-800-499-0229 *TDD	1-207-624-5443	1-207-623-1797 1-800-750-5353

* In-state only

State	Long-Term Care Ombudsman	State Survey Agency	State Health Insurance Assistance Program
Maryland	1-410-767-1091 1-800-243-3425 * 1-410-767-1083 TDD	1-410-764-2750 1-800-492-6005 1-800-735-2258 TDD	1-410-767-1100 1-800-243-3425 * 1-410-767-1083 TDD
Massachusetts	1-617-727-7750 1-800-882-2003 1-800-872-0166 TDD	1-617-753-8000	1-617-727-7750 1-800-882-2003 * 1-800-872-0166 TDD
Michigan	1-517-886-6797 1-800-292-7852 *	1-517-334-8408 1-800-882-6006 *	1-517-373-8230 1-800-803-7174 1-517-373-4096 TDD
Minnesota	1-651-296-0382 1-800-657-3591 1-800-627-3529 TDD	1-651-215-8700 1-800-369-7994 1-651-297-5353 TDD	1-651-333-2433 1-800-333-2433 1-800-627-3529 TDD
Mississippi	1-601-359-4929 1-800-948-3090	1-601-354-7300 1-800-227-7308	1-601-359-4929 1-800-948-3090
Missouri	1-573-526-0727 1-800-309-3282 1-800-735-2966 TDD	1-573-751-6302	1-573-893-7900 ext. 300 1-800-390-3330
Montana	1-406-444-4676 1-800-332-2272 *	1-406-444-2099	1-406-444-7781 1-800-332-2272 * 1-800-833-8503 TDD
Nebraska	1-402-471-2307 1-800-942-7830 *	1-402-471-4961 1-402-471-9570 TDD	1-402-471-2201 1-800-234-7119 1-800-833-7352 TDD

* In-state only

State	Long-Term Care Ombudsman	State Survey Agency	State Health Insurance Assistance Program
Nevada	1-775-486-3545 1-800-992-0900 * ext. 3545 1-775-486-3236 TDD	1-775-687-4475 1-800-225-3414	1-775-486-3478 1-800-307-4444
New Hampshire	1-603-271-4375 1-800-442-5640 * 1-800-735-2964 TDD	1-603-271-4592 1-800-852-3345 *	1-603-225-9000 1-800-852-3388 *
New Jersey	1-609-588-3146 1-800-792-8820 *	1-609-292-7834 1-800-367-6543 *	1-609-588-3139 1-800-792-8820 *
New Mexico	1-505-827-7640 1-800-432-2080 *	1-505-827-4200 1-800-752-8649 *	1-505-827-7640 1-800-432-2080 *
New York	1-518-474-0180 1-800-342-9871 *	1-518-474-6630 1-800-342-3736 *	1-212-869-3850 1-800-333-4114
North Carolina	1-919-733-8395 1-800-662-7030 *	1-919-733-7461 1-800-624-3004 *	1-919-733-0111 1-800-443-9354 * 1-919-715-0319 TDD
North Dakota	1-701-328-8934 1-800-755-8521	1-701-328-2352 1-701-328-2068 TDD	1-701-328-2440 1-800-247-0560 * 1-800-366-6888 TDD
N. Mariana Islands	1-808-586-0100 1-800-999-4454 *	1-808-586-4080 1-800-468-4644 1-800-586-4684 TDD	1-808-586-7299

* In-state only

State	Long-Term Care Ombudsman	State Survey Agency	State Health Insurance Assistance Program
Ohio	1-614-644-7922 1-800-282-1206 1-614-466-6191 TDD	1-614-752-9524 1-800-342-0553 * 1-614-752-9172 TDD	1-614-644-3458 1-800-686-1578 *
Oklahoma	1-405-521-6734	1-405-271-6868 1-800-234-7258 *	1-405-521-6628 1-800-763-2828 *
Oregon	1-503-378-6533 1-800-522-2602 *	1-503-945-5832 1-800-232-3020 * 1-503-954-5832 TDD	1-503-947-7984 1-800-722-4134 1-503-954-5832 TDD
Pennsylvania	1-717-783-1550	1-717-787-1816 1-800-254-5164	1-717-783-8975 1-800-783-7067
Puerto Rico	1-787-725-1515	1-787-782-0120 1-800-981-8666	1-787-721-8590 1-877-725-4300 *
Rhode Island	1-401-785-3340	1-401-222-2566	1-401-222-2880 1-800-322-2880 *
South Carolina	1-803-898-2850 1-800-868-9095 *	1-803-737-7205 1-800-922-6735 *	1-803-898-2850 1-800-868-9095 *
South Dakota	1-605-773-3656	1-605-773-3356	1-605-773-3656 1-800-822-8804
Tennessee	1-615-741-2056 1-800-848-0298 TDD	1-615-862-5900	1-615-741-4955 1-800-525-2816

* In-state only

State	Long-Term Care Ombudsman	State Survey Agency	State Health Insurance Assistance Program
Texas	1-512-424-6840 1-800-252-2412	1-512-834-6650 1-800-228-1570	1-512-424-6840 1-800-252-9240
Utah	1-801-538-3910 1-800-541-7735 *	1-801-538-6559 1-800-999-7339 *	1-801-538-3910 1-800-541-7735 *
Vermont	1-802-863-5620 1-800-747-5022 *	1-802-241-2345 1-800-564-1612	1-802-748-5182 1-800-642-5119 *
Virgin Islands	1-787-725-1515	1-340-774-2991	1-340-778-6311 ext.2338
Virginia	1-804-644-2804 1-800-552-3402 *	1-804-367-2100 1-800-955-1819 1-804-828-1120 TDD	1-804-662-9333 1-800-552-3402
Washington	1-800-562-6028	1-360-705-6655 1-360-664-0064 TDD	1-360-407-0383 1-800-397-4422 * 1-360-493-2637 TDD
West Virginia	1-304-558-3317	1-304-558-0050 1-800-442-2888 *	1-304-558-3317 1-877-987-4463
Wisconsin	1-608-266-7159 1-800-815-0015	1-608-266-8481 1-800-642-6552 * 1-800-947-3529 TDD	1-608-266-2536 1-800-242-1060
Wyoming	1-307-322-5553 1-307-635-1245	1-307-777-7123 1-307-777-5648 TDD	1-307-856-6880 1-800-856-4398

* In-state only

CHECK LIST

Check lists can help you evaluate the nursing homes that you visit. Use a new check list for each home you visit. Then, compare the lists. This will help you select a nursing home that is a good choice for you or your relative.

FACILITY NAME: _____ DATE VISITED: _____

ADDRESS: _____

I. Basic Information

	YES	NO
1. Medicare Certified	☐	☐
2. Medicaid Certified	☐	☐
3. Accepting New Patients	☐	☐
4. Waiting Period for Admission	☐	☐

5. Number of Beds in each category available to you _____

USEFUL TIPS

- Generally, skilled nursing care is available only for a short period of time after a hospitalization. Basic nursing care is for a much longer period of time. If a facility offers both types of care, learn if residents may transfer between levels of care within the nursing home without having to move from their old room or from the nursing home.
- Nursing homes that only take Medicaid residents might offer longer term but less intensive levels of care. Homes that do not accept Medicaid payment may make a resident move when Medicare or the resident's own money runs out.
- An occupancy rate is the total number of residents currently living in a nursing home divided by the home's total number of beds. Occupancy rates vary by area, depending on the overall number of available nursing home beds.

II. Nursing Home Information

	YES	NO
1. The home and the current administrator are licensed	☐	☐
2. The home conducts background checks on all staff	☐	☐
3. The home has Special Services Units	☐	☐
4. The home has Abuse Prevention Training	☐	☐

Useful Tips

- LICENSURE: The nursing home and its administrator should be licensed by the State to operate.
- BACKGROUND CHECKS: Do the nursing home's procedures to screen potential employees for a history of abuse meet your State's requirements? Your State's Ombudsman program might be able to help you with this information.
- SPECIAL SERVICES: If a nursing home has special service units, learn if there are separate waiting periods or facility guidelines for when residents would be moved on or off the special unit. Some examples are: rehabilitation, Alzheimers, and hospice.
- STAFF TRAINING: Do the nursing home's training programs educate employees about how to recognize resident abuse and neglect, how to deal with aggressive or difficult residents, and how to deal with the stress of caring for so many needs? Are there clear procedures to identify events or trends that might lead to abuse and neglect, and on how to investigate, report, and resolve your complaints?
- LOSS PREVENTION: Are there policies or procedures to safeguard resident possessions?

For Parts three through six, give the nursing home a grade from one to five. One is poor, five is best.

III. Quality of Life

		GRADE				
		POOR				BEST
1.	Residents can make choices about their daily routine. Examples are when to go to bed or get up, when to bathe, or when to eat.	1	2	3	4	5
2.	The interaction between staff and patient is warm and respectful.	1	2	3	4	5
3.	The home is easy to visit for friends and family.	1	2	3	4	5
4.	The nursing home meets your cultural, religious, or language needs.	1	2	3	4	5
5.	The nursing home smells and looks clean and is well-lighted.	1	2	3	4	5
6.	The home maintains comfortable temperatures.	1	2	3	4	5
7.	The resident rooms have personal articles and furniture.	1	2	3	4	5
8.	The public and resident rooms have comfortable furniture.	1	2	3	4	5
9.	The nursing home and its dining room are generally quiet.	1	2	3	4	5
10.	Residents may choose from a variety of activities that they like.	1	2	3	4	5
11.	The nursing home has outside volunteer groups.	1	2	3	4	5
12.	The nursing home has outdoor areas for resident use and helps residents to get outside.	1	2	3	4	5

TOTAL _____

IV. Quality of Care

		GRADE				
		Poor				Best
1.	The facility corrected any Quality of Care deficiencies that were in the State inspection report.	1	2	3	4	5
2.	Residents may continue to see their personal physician.	1	2	3	4	5
3.	Residents are clean, appropriately dressed, and well groomed.	1	2	3	4	5
4.	Nursing home staff respond quickly to calls for help.	1	2	3	4	5
5.	The administrator and staff seem comfortable with each other and with the residents.	1	2	3	4	5
6.	Residents have the same care givers on a daily basis.	1	2	3	4	5
7.	There are enough staff at night and on weekends or holidays to care for each resident.	1	2	3	4	5
8.	The home has an arrangement for emergency situations with a nearby hospital.	1	2	3	4	5
9.	The family and residents councils are independent from the nursing home's management.	1	2	3	4	5
10.	Care plan meetings are held at times that are easy for residents and their family members to attend.	1	2	3	4	5

Total _____

Useful Tips

- A good patient/staff ratio is important to good care, but you should also consider other care factors. Examples are staff training programs and how long staff stay at the home. If staff changes frequently, ask why.
- Good care plans are essential to good care. They should be put together by a team of providers and family and updated as often as necessary.

V. Nutrition and Hydration

		GRADE				
		Poor				Best
1.	The home corrected any deficiencies in these areas that were on the recent survey.	1	2	3	4	5
2.	There are enough staff to assist each resident who requires help with eating.	1	2	3	4	5
3.	The food smells and looks good and is served at proper temperatures.	1	2	3	4	5
4.	Residents are offered choices of food at mealtimes.	1	2	3	4	5
5.	Residents' weight is routinely monitored.	1	2	3	4	5
6.	There are water pitchers and glasses on tables in the rooms.	1	2	3	4	5
7.	Staff encourage residents to drink if they are not able to do so on their own.	1	2	3	4	5
8.	Nutritious snacks are available during the day and evening.	1	2	3	4	5
9.	The dining room environment encourages residents to relax, socialize, and enjoy their food.	1	2	3	4	5
		Total				

Useful Tips

- Ask the professional staff how the medicine a resident takes can effect what they eat and how often they may want something to drink.
- Visit at meal time. Are residents rushed through meals or do they have time to finish eating and to use the meal as an opportunity to socialize with each other?
- Sometimes the food a home serves is fine, but a resident still will not eat. Like everyone, nursing home residents like some control over their diet. Can they select their meals from a menu or select their mealtime?
- If residents need help eating, do care plans specify what type of assistance they will receive?

VI. Safety	GRADE Poor				Best
1. There are handrails in the hallways and grab bars in the bathrooms.	1	2	3	4	5
2. Exits are clearly marked.	1	2	3	4	5
3. Spills and other accidents are cleaned up quickly.	1	2	3	4	5
4. Hallways are free of clutter and well-lighted.	1	2	3	4	5
5. There are enough staff to help move residents quickly in an emergency.	1	2	3	4	5
6. The nursing home has smoke detectors and sprinklers.	1	2	3	4	5

Total _____

Facility Total _____

Other Observations:

DEFINITIONS

ABUSE	The willful infliction of injury, unreasonable confinement, intimidation, or punishment with physical harm, pain, or mental anguish.
ASSESSMENT	The rating or evaluation of a resident's health status and needs while they are in a nursing home.
CARE PLAN	A written strategy that states what services a resident will receive to reach and keep their best possible physical, mental, and psychosocial well being.
DEFICIENCY	A way to show that a nursing home failed to meet one or more Federal or State requirements.
DEHYDRATION	A serious condition where a body's loss of fluids is more than the amount of fluid taken into the body.
MALNUTRITION	A condition caused by the lack (or too much) of essential nutrients.
MEDIATE	To settle differences between two or more parties.
NEGLECT	Failure to provide goods or services that are necessary to avoid physical harm or mental anguish or illness.
LONG-TERM CARE OMBUDSMAN	A supporter for nursing home residents who works to resolve problems between residents and nursing homes.
RESPITE CARE	Care given to a nursing home resident so that the usual care giver can rest.
RESTRAINT	Any manual method or physical or mechanical device, material, or equipment attached to or near a resident's body that he/she cannot remove easily and which prevents freedom of movement or normal access to one's own body.

A chemical drug used for discipline or convenience and is not needed to treat medical symptoms.

For single copies, please call 1-800-MEDICARE (1-800-633-4227).

¿Necesita usted una copia en Español? Llame al 1-800-633-4227.

If you use a TTY/TDD, please call 1-877-486-2048.

This publication is also available in Braille and Audiocassette.

This publication is also on the Internet at HCFA's web site address, www.medicare.gov.

U. S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Health Care Financing Administration
7500 Security Boulevard
Baltimore, Maryland 21244-1850

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August 1999

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Medicare & You
The knowledge to make good decisions

Do You Need Help to Pay Health Care Costs?

Where may I get help to pay health care costs?

Medicaid has programs that pay some or all of Medicare's premiums and may also pay Medicare deductibles and coinsurance for certain people who are entitled to Medicare and have a low income. You must have Medicare Hospital Insurance (Part A). If you are not sure if you have Part A, look on your Medicare card (red, white, and blue card). It will show "Hospital Insurance (Part A)" on the lower left corner of the card. You can also call your local Social Security Administration office, or call SSA at 1-800-772-1213.

If you have Part A, your income is limited (see below), and your financial resources such as bank accounts, stocks, and bonds are not more than $4,000 for an individual, or $6,000 for a couple, you may qualify for assistance as a Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), or Qualifying Individual (QI).

For more information about these programs, call your State, county, or local medical assistance office. Check your phone directory for the office nearest you. You can find these offices listed under Medicaid, Social Services, Medical Assistance, Public Assistance, Human Services, or Community Services. You may also call Medicare at 1-800-MEDICARE (1-800-633-4227) (TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) to find the phone number in your State.

2000 Monthly Income Limit*

	Individual	Couple	Program Pays Medicare's...
QMB	$716	$958	Premiums, deductibles, and coinsurance
SLMB	$855	$1,145	Monthly Part B premiums
QI-1	$960	$1,286	Monthly Part B premiums
QI-2	$1,238	$1,661	A small part of the monthly Part B premium

*Slightly higher amounts are allowed in Alaska and Hawaii. Income limits will increase slightly in 2001, and new limits will be available by April 1, 2001. These programs may not be available in Guam, Puerto Rico, the Virgin Islands, the Northern Mariana Islands, and American Samoa.

Do you or someone you know have children under age 19 that are not covered by health insurance? There is help! A new State Children's Health Insurance Program is available. To find out how to qualify for the program, you can call the national toll-free number at 1-877-KIDS-NOW (1-877-543-7669). This number will automatically connect you to your State's insurance program for children.

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Revised March 2000

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Medicare & You
The knowledge to make good decisions

¿Necesita Ayuda Para Pagar Los Costos del Cuidado de su Salud?

¿Dónde conseguiría yo ayuda para pagar los costos del cuidado de la salud?

Medicaid tiene programas que pagan algunas o todas las primas de Medicare e incluso pueden pagar deducibles y seguro complementario de Medicare para aquellas personas que califiquen para Medicare y tengan bajos ingresos. Usted tiene que tener Seguro de Hospital Medicare (Parte A). Si no está seguro de tener la "Parte A", mire en su tarjeta Medicare (tarjeta roja, blanca y azul). La tarjeta dice "Hospital Insurance (Part A)" en la esquina inferior izquierda. También puede llamar a la oficina de la Administración del Seguro Social más cercana, o llamar al 1-800-772-1213.

Si usted tiene la "Parte A", sus ingresos son limitados (mire abajo la tabla), y sus recursos financieros, tales como cuentas de bancos, acciones y bonos no exceden los $4,000 dólares para un individuo, o $6,000 dólares para una pareja, usted podría calificar para asistencia como un Beneficiario Calificado de Medicare (QMB), Beneficiario de Medicare con Bajos Ingresos Específicos (SLMB), o Individuo Calificado (QI).

Para más información sobre estos programas, llame a su Estado, condado u oficina de asistencia médica local. Busque en cualquier guía (directorio telefónico) la oficina más cercana a usted. Encontrará estas oficinas listadas bajo los titulares de Medicaid, Servicios Sociales, Asistencia Médica, Asistencia Pública, Servicios Humanos, o Servicios Comunitarios. También puede llamar a Medicare al 1-800-MEDICARE (1-800-633-4227) (TTY/TDD: 1-877-486-2048 para personas con impedimento auditivo o lenguaje oral) para conseguir el número de teléfono en su Estado.

2000 Límite Mensual de Ingresos*

	Individual	Pareja	Beneficios - Paga Medicare
QMB	$ 716	$ 958	Primas, deducibles, y seguro complementario
SLMB	$ 855	$ 1,145	Primas mensuales "Parte B"
QI-1	$ 960	$ 1,286	Primas mensuales "Parte B"
QI-2	$ 1,238	$ 1,661	Una pequeña parte de la prima mensual de la "Parte B"

*Cantidades un poco más altas están permitidas en Alaska y Hawaii. Los límites de ingreso aumentarán un poco en el 2001, y estarán disponibles a partir del 1 de abril del 2001. Estos programas posiblemente no están disponibles en Guam, Puerto Rico, las Islas Vírgines, las Islas Marianas del Norte, y Samoa Americana.

¿Tiene usted o alguien que conozca niños menores de 19 años que no estén cubiertos por un seguro médico? Existe ayuda! Un nuevo Programa de Seguros para la Salud de los Niños se encuentra disponible en su Estado. Para averiguar sobre los requisitos del programa, puede llamar gratis al número nacional 1-877-KIDS-NOW (1-877-543-7669). Este número le conectará automáticamente con el programa de seguro para niños de su Estado.

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Revised March 2000

Medicare & You
The knowledge to make good decisions

Medicare Preventive Services...

...To Help Keep You Healthy

There are steps you can take to lower your risk of disease and illness. Medicare is providing coverage for these preventive services to help you stay healthy. Medicare will cover:

- Tests for breast cancer, cervical cancer, vaginal cancer, and colorectal cancer;
- Bone mass measurements;
- Diabetes monitoring and diabetes self-management; and
- Flu, pneumonia, and Hepatitis B shots.
- Prostate cancer screening tests.

These new, valuable benefits from Medicare may be the key to long lasting good health. Talk with your doctor about your risk of developing these health problems and your need for these preventive services.

This pamphlet includes:

- A chart that explains which preventive services are covered by Medicare, for whom they are covered, and what you pay.
- Cards with more detailed information on some of the preventive benefits. You can tear these out and put them on your calendar or refrigerator as a reminder, or you can take them to your doctor so that you can talk about the preventive services that Medicare covers.

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

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Revised May 2000

Medicare Preventive Services — Added Benefits to Help You Stay Healthy

Covered Service	Who is Covered	What You Pay
Bone Mass Measurements: Varies with your health status.	Certain people with Medicare who are at risk for losing bone mass.	20% of the Medicare-approved amount or a set coinsurance amour after the yearly Part B deductible.
Colorectal Cancer Screenings: • **Fecal Occult Blood Test** - Once every 12 months. • **Flexible Sigmoidoscopy** - Once every 48 months. • **Colonoscopy** - Once every 24 months if you are at high risk for cancer of the colon. • **Barium Enema** - Doctor can substitute for sigmoidoscopy or colonoscopy.	All people with Medicare age 50 and older. However, there is no age limit for having a colonoscopy.	Nothing for the fecal occult blood test. For all other tests, 20% of the Medicare-approved amount after the yearly Part B deductible. Your costs may be different if you get these services in a hospital.
Diabetes Monitoring: Includes coverage for glucose monitors, test strips, and lancets. Diabetes self-management training.	All people with Medicare who have diabetes (insulin users and non-users). If requested by your doctor.	20% of the Medicare-approved amount after the yearly Part B deductible.
Mammogram Screening: Once every 12 months. You can get one baseline mammogram between ages 35 and 39.	All women with Medicare age 40 and older.	20% of the Medicare-approved amount with no Part B deductible.
Pap Smear and Pelvic Examination: (Includes a clinical breast exam) Once every 36 months. Once every 12 months if you are at high risk for cervical or vaginal cancer, or are of childbearing age and had an abnormal Pap smear in the past 36 months.	All women with Medicare.	Nothing for the Pap smear lab test. For Pap smear collection, pelvic and breast exams, 20% of the Medicare-approved amount or a set coinsurance amount with no Part B deductible.
Prostate Cancer Screening: • **Digial Rectal Examination** - Once every 12 months. • **Prostate Specific Antigen (PSA) Test** - Once every 12 months.	All men with Medicare age 50 and older.	20% of the Medicare-approved amount after the yearly Part B deductible. No coinsurance and no Part B deductible for the PSA Test.
Shots (Vaccinations): • **Flu Shot** - Once every flu season. • **Pneumonia Shot** - One may be all you ever need, ask your doctor. • **Hepatitis B Shot** - If you are at medium to high risk for hepatitis.	All people with Medicare.	Nothing for flu or pneumonia shots if the health care provider accepts the assignment. For Hepatitis B shots, 20% of the Medicare-approved amount or a set coinsurance amount after the yearly Part B deductible.

Colorectal Cancer Screening

Which colorectal screening benefits are covered under Medicare?

Medicare covers:

- A screening fecal occult blood test (FOBT),
- Flexible sigmoidoscopy, and
- Screening colonoscopy.

The FOBT and the flexible sigmoidoscopy are considered to be general preventive screenings. However, if you are at high risk for colorectal cancer, Medicare will cover a screening colonoscopy. Medicare also covers a barium enema if your doctor decides that a barium enema should be performed instead of a flexible sigmoidoscopy or screening colonoscopy. *(over)*

Call 1-800-4CANCER or visit www.nci.nih.gov for more health information.

Medicare Preventive Services

Mammography Screening

Which breast cancer screening benefits are covered under Medicare? How often are they covered?

Medicare will pay for a mammogram every 12 months. Regular mammography screenings can save your life.

Who is eligible to receive a mammography screening?

All women with Medicare age 40 or older are eligible for mammography screenings every 12 months. Medicare also pays for one baseline mammogram for female Medicare beneficiaries between ages 35 and 39. *(over)*

Call 1-800-4CANCER or visit www.nci.nih.gov for more health information.

Medicare Preventive Services

Flu, Pneumonia, and Hepatitis B Shots (Vaccinations)

Which preventive shots are covered by Medicare?

Flu shots, pneumonia shots, and Hepatitis B shots are covered by Medicare. Flu, pneumonia, and hepatitis can be life threatening to the elderly.

Who is eligible to receive these shots?

All people with Medicare are eligible for flu shots and pneumonia shots. Hepatitis B shots are covered only for persons at risk for Hepatitis B, such as those with end-stage renal disease or hemophilia.

(over)

Call 1-800-MEDICARE or visit www.medicare.gov for more health information.

Medicare Preventive Services

Pap Smear and Pelvic Exams (Includes Clinical Breast Exam)

Does Medicare cover screenings to find cervical and vaginal cancers?

Medicare covers Pap smears and pelvic exams to check for cervical and vaginal cancers. In addition to the pelvic exam, a clinical breast exam is also covered to check for breast cancer.

Who is eligible to receive Pap smears and pelvic exams?

All women with Medicare are eligible. *(over)*

Call 1-800-4CANCER or visit www.nci.nih.gov for more health information.

Mammography Screening—*Continued*

Am I at high risk for breast cancer?

Simply getting older increases breast cancer risk. The older you are, the greater your chance of getting breast cancer. However, several factors that could place you at higher risk include:

- If you had breast cancer before;
- If you have a family history of breast cancer—that is, a mother, sister, daughter or two or more close relatives who had breast cancer; or
- If you had your first baby after the age of 30, or if you never have had a baby.

How do I get more information about breast cancer and mammography screening?

Discuss breast cancer risk or screening with your doctor, or call the National Cancer Institute at 1–800–4–CANCER or visit www.nci.nih.gov for more information.

Pap Smear and Pelvic Exams—*Continued*

How often will Medicare cover a Pap smear and pelvic exam?

A Pap smear and pelvic exam are covered by Medicare once every 36 months. However, if you are a woman of child bearing age and have had an abnormal Pap smear within the past 36 months, or you are at high risk for cervical or vaginal cancer, Medicare will cover a Pap smear and pelvic exam every 12 months.

Who is at high risk for cervical or vaginal cancer?

Risk for cervical cancer is increased if you have had an abnormal Pap test, if you have had cancer before, or if you have been infected with the human papilloma viruses (HPVs). If you began having sexual intercourse before the age of 16, or if you have had many sexual partners, you also have a greater cervical cancer risk. Risk for vaginal cancer is increased for daughters of women who took DES during pregnancy.

Colorectal Cancer Screening—*Continued*

Who is eligible to get a colorectal screening?

All people with Medicare age 50 or older are eligible for colorectal screenings. However, there is no age limit for colonoscopies.

How often will Medicare cover colorectal exams?

A fecal occult blood test is covered once every 12 months and a sigmoidoscopy once every 48 months. If you are at high risk for colorectal cancer, Medicare covers a colonoscopy every 24 months. A doctor can subsitute a barium enema for a sigmoidoscopy or colonoscopy.

Who is at high risk for colorectal cancer?

After age 40, colorectal cancer risk increases with age and throughout life. Your risk is greater if you have a history of inflammatory bowel disease, colorectal cancer, or polyps. You are also at greater risk if you have a family history of colorectal cancer or polyps, or have certain hereditary syndromes.

Flu, Pneumonia and Hepatitis B Shots—*Continued*

How often will Medicare cover these shots?

Medicare pays for a flu shot every year. You should get one each year between October and December. Medicare will also pay for a pneumonia shot, which you should get by age 65. Most people only need to get this shot once in their lifetime. Medicare will pay for a Hepatitis B shot if you are at medium to high risk for Hepatitis B.

Who is at risk for flu, pneumonia, or Hepatitis B?

Flu and pneumonia infections can be life-threatening for elderly people. All adults 65 and older should get flu and pneumonia shots. Those at medium or high risk for Hepatitis B include individuals with end-stage renal disease or hemophilia.

Medicare & You
The knowledge to make good decisions

Worksheet for Comparing Medicare Health Plans

Health Care Financing Administration
The Federal Medicare Agency

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Information on Differences Among Medicare Health Plans and Worksheet Sections

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How to Use this Worksheet:

Write the plan names in the blocks with the word "Plan." Use the rest of the blocks under each plan to fill in the answers to each question for that plan.

Introduction

In Medicare, you may be able to get your health care coverage from:

The Original Medicare Plan

The Original Medicare Plan is also known as "fee-for service." This plan, offered by the federal government, is available nationwide. You may go to any doctor, specialist, or hospital that accepts Medicare. You are usually charged a fee for each health care service or supply you get.

Or, you can get your coverage through another Medicare health plan under Medicare + Choice. Congress created the Medicare + Choice program to let more private insurance companies offer coverage to people in Medicare. Some of your choices may include:

A Medicare managed care plan, like an HMO

A Medicare managed care plan, sometimes called an HMO, is a health plan offered by private insurance companies. In most managed care plans, you can only go to certain doctors and hospitals that agree to treat members of the plan.

A Medicare Private Fee-for-Service plan

A Private Fee-for-Service plan is a new type of health care plan that is available in some areas of the country. It is a Medicare health plan offered by a private insurance company. It is not the same as the Original Medicare Plan, which is offered by the federal government. If you have a Private Fee-for-Service plan, you may go to any doctor or hospital that accepts the plan's payment.

You may have heard about Medicare Medical Savings Accounts (MSAs). At the time this book was printed, no private insurance companies had decided to offer MSAs to people with Medicare. To find out if MSAs have become available in your area or to get a booklet about this type of plan, call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired).

No matter how you get your Medicare benefits, you are still in the Medicare program. In every Medicare health plan, you get all the Medicare Part A and Part B covered services.

Introduction

Medicare health plans may have differences among them, such as:
- cost
- choice of providers
- extra benefits
- convenience
- quality
- complaints

Use this worksheet to ask the questions that are important to you and compare the answers. The information you get will help you compare plans and make the health plan choice that is right for you. Write in the plan names and the answers from each plan to keep a record.

Each worksheet section begins with important information about the differences among the Original Medicare Plan, Medicare managed care plans, and Private Fee-for-Service plans.

You can get up-to-date information about the Medicare health plans available in your area by:

- Looking at www.medicare.gov on the Internet. Your local library or senior center may be able to help you find this information on their computers.

- Calling 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired).

- Calling the State Health Insurance Assistance Program in your area. The number for your state will be listed in your copy of *Medicare & You,* or can be found at www.medicare.gov on the Internet.

Cost

In all Medicare health plans, you must pay the monthly Part B premium.

In the Original Medicare Plan, you must pay additional costs such as hospital deductibles, coinsurance, and copayments. The Original Medicare Plan does not pay for outpatient prescription drugs, with only a few exceptions. You may be able to cover these out-of-pocket costs by buying a Medigap policy or by joining one of the other Medicare health plans.

The additional costs in Medicare managed care plans and Private Fee-for-Service plans depend on whether the plan charges a monthly premium in addition to your monthly Part B premium of $45.50 in 2000, how much the plan decides you must pay for each doctor visit (copayment), and, for Private Fee-for-Service plans, whether providers are allowed to bill extra. Costs vary from plan to plan.

In most Medicare managed care plans, you can only go to certain doctors and hospitals that agree to treat members of the plan. Some managed care plans offer a point-of-service option. This option allows you to go to other doctors and hospitals, who are not part of the plan. Most of the time, this option costs you more.

All Medicare managed care plans must allow you to get emergency care whenever you need it from any provider in the United States. You do not need permission from your primary care doctor first. Your plan must pay for emergency care. In a Medicare managed care plan, you get urgently needed care from your primary care doctor. However, if you are out of the plan's service area and cannot wait until you return home, your plan must pay for urgently needed care.

In Private Fee-for-Service plans, you can go to any doctor or hospital that accepts the terms of the plan's payment. You pay and the insurance company pays a fee for each doctor visit or service you get. The insurance company, rather than the Medicare program, decides how much it pays, and how much you pay, for the services you get.

Cost

If you are in a Medicare managed care plan, or a Private Fee-for-Service plan, call the plan and ask...	Plan:	Plan:	Plan:
Will I have to pay a monthly premium in addition to my monthly Part B premium?			
Will I be charged copayments for doctor visits?			
Does the plan pay for prescriptions? How much?			
Does the plan have maximum amounts it will pay for different services? How much?			
Will I have to pay a deductible or coinsurance for inpatient hospital services, home health, or skilled nursing facility services?			

Cost

If you are in a Medicare managed care plan, call the plan and ask…	Plan:	Plan:	Plan:
Will I have to pay more if I use a doctor or hospital outside the plan? How much?			

If you are in a Private Fee-for-Service plan, call the plan and ask…	**Plan:**	**Plan:**	**Plan:**
Does the plan set limits on what doctors and hospitals charge me?			
Does the plan have any "pre-notification" requirements (for example, a requirement that I notify the plan of any planned inpatient admissions)?			

Doctors, Hospitals, and Other Health Care Professionals

In the Original Medicare Plan, and the Original Medicare Plan with a Medigap policy, you may use any provider who accepts Medicare. In Private Fee-for-Service plans, you may use any provider who accepts the terms of the plan's payment.

In most Medicare managed care plans, you can only go to certain doctors and hospitals that agree to treat members of the plan. Generally, you can only see a specialist (like a cardiologist) when you get a referral, which means your primary care doctor says it is OK to go. If you like your current doctor and want to continue seeing him or her after you join a plan, first ask if he or she belongs to any of the plans you are thinking of joining.

If you are in a Medicare managed care plan, call the plan and ask....	**Plan:**	**Plan:**	**Plan:**
Is there a selection of the doctors, health professionals, and hospitals that I might need?			
Can I see the same doctor on most visits?			
Can I change doctors once I am in the plan?			
What's the plan's policy if it doesn't have the type of specialist I need?			

If you are in a Medicare managed care plan, call the doctor and ask....	**Plan:**	**Plan:**	**Plan:**
Are my doctors in the plan?			
Can I get the doctor I want? Is he/she accepting new patients under that plan?			

If you are in a Private Fee-for-Service plan, call the doctor and ask...	Plan:	Plan:	Plan:
Does the doctor know and accept the terms of the plan's payment?			
Is the doctor taking new patients?			

Extra Benefits

The types of services described in this section are in addition to Medicare Part A and Part B covered services. Medigap policies, Medicare managed care plans, and Private Fee-for-Service plans often have extra benefits. For example, in Private Fee-for-Service plans, you may be able to get coverage for additional days in the hospital.

If you are in a Medicare managed care plan, or a Private Fee-for-Service plan, call the plan and ask: Does the plan cover/provide...	**Plan:**	**Plan:**	**Plan:**
Routine physicals?			
Eye exams, glasses, contacts?			
Hearing exams and hearing aids?			
Dental exams/treatments?			
Programs that focus on helping members with specific, chronic conditions such as asthma, diabetes, or heart conditions?			
Programs that help with needs like respite care, care giver services, and other social services?			
Wellness programs and classes that help members lose weight, eat properly, stop smoking, or exercise appropriately? Is there any charge?			
Other extra benefits I may be interested in:			

Prescription Drugs - An Important Extra Benefit

The Original Medicare Plan does not pay for outpatient prescription drugs, with only a few exceptions. Some Medigap policies help with the cost of prescription drugs, and some Medicare managed care plans and Private Fee-for-Service plans may cover some of the cost for prescription drugs.

If you are in a Medicare managed care plan, or a Private Fee-for-Service plan, call the plan and ask:	**Plan:**	**Plan:**	**Plan:**
Does the plan cover the drugs I use?			
May I use my regular pharmacy?			
Are mail-order prescriptions available?			
What is the annual or quarterly dollar limits on prescription drug coverage?			
Will I have to pay more if I prefer to use brand name instead of generic drugs?			
Is there a maximum out-of-pocket cost for prescription drugs? What is it?			
Does the plan limit the prescription drugs it pays for to those on a list of drugs (called a formulary)?			

Convenience

Location, hours of operation, and similar details may be important to you. Call each plan to decide if it is convenient for you.

If you are in a Medicare managed care plan, or a Private Fee-for-Service plan, call the doctor or health care provider and ask...	**Plan:**	**Plan:**	**Plan:**
Are the hours and location of doctors, clinics, and other health care providers convenient?			
Are the doctors' offices, labs, and other services convenient?			

If you are in a Medicare managed care plan, or a Private Fee-for-Service plan, call the plan and ask...	**Plan:**	**Plan:**	**Plan:**
How fast can I be seen for urgent (non-emergency) care?			
Is there a telephone hotline for medical advice?			

All Medicare doctors must be licensed in their state. Medicare certifies hospitals, nursing homes, and suppliers. Medicare also requires that Medicare managed care plans have quality assurance programs to get a Medicare contract. Medicare managed care plans and Private Fee-for-Service plans must meet standards set by state and federal governments.

Beyond these basic standards, the quality of care in plans may vary. Three main types of information will tell you about the quality of care in a Medicare managed care plan. Note: Quality and disenrollment information is not available yet for Medicare Private Fee-for-Service plans because they are new.

1) Accreditation

This is an additional seal of approval by a private, independent, non-profit group, which evaluates a plan and gives it an official status based on that evaluation. Organizations that accredit Medicare managed care plans include the National Committee for Quality Assurance, the Joint Commission on Accreditation of Health Care Organizations, and the American Accreditation Healthcare Commission.

2) Quality information

Quality is how well the plan keeps its members healthy or treats them when they are sick. Good quality health care means doing the right thing at the right time, in the right way for the right person—and getting the best possible results. Medicare has quality information for most Medicare managed care plans on more than 10 different quality measures. Quality measures include information from satisfaction surveys and performance measures.

- Satisfaction surveys. Medicare gets information from people like you in Medicare managed care plans about how satisfied they are with their plans. The survey used to collect this information is called the Medicare Satisfaction Survey, or the Medicare Consumer Assessment of Health Plans Survey (CAHPS)t. We use an outside research company to do the survey and report the results back to you.

2) Quality information (continued)

- Performance measures. Managed care plans keep track of some health care services they give you and report that care to Medicare. Medicare collects this information, sometimes called "performance measures," from the Health Plan Employer Data and Information Set (HEDIS)t. We carefully check this information before you see it.

3) Plan disenrollment information

This information shows the percentage of people with Medicare who chose to leave their Medicare managed care plan and the percentage who stayed during a year. The information is collected from Medicare managed care plans and does not include members who died, moved out of the area, were not eligible for managed care under Medicare, or whose plan decided not to serve people with Medicare in that area. Starting in 2001, you will be able to find out why people chose to leave a Medicare managed care plan.

Plan Quality and Disenrollment Information

If you are in a Medicare managed care plan, or a Private Fee-for-Service plan, ask...	**Plan:**	**Plan:**	**Plan:**
Your friends or relatives who are in the plan: Do they like the plan?			
Do they get the care they need when they need it?			
The plan: Is the plan accredited by an independent group?			
Where available: How does the plan compare on performance measures and consumer satisfaction surveys?			

For more information:
Call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) to get quality and other information about the Medicare health plans in your area, or look on the Internet at www.medicare.gov and click on Medicare Health Plan Compare.

Note: For some plans, quality and disenrollment information is not available because the plan is too new to be measured; the number of Medicare members was too small to report; or Medicare did not require the plan to report this information.

You have a right to appeal any decision about your Medicare services. If you are in the Original Medicare Plan, you can file an appeal if you think Medicare should have paid for, or did not pay enough for, an item or service you received. Your appeal rights are on the back of the Explanation of Medicare Benefits or Medicare Summary Notice that is mailed to you from the company that handles bills for Medicare. In addition, Medicare has a contract with local PROs (Peer Review Organizations). You may call your PRO about quality of care concerns, filing an appeal or grievance (complaint), or questions about your rights as a hospital patient. For example, if you think the hospital is making you leave too soon, you may be able to stay in the hospital at no charge while the PRO reviews your case.

If you are in a Medicare managed care plan or Private Fee-for-Service plan, you can file an appeal if your plan will not pay for, does not allow, or stops a service that you think should be covered or provided. If you think your health could be seriously harmed by waiting for a decision about a service, ask the plan for a fast decision. The plan must reach a decision within 72 hours. The plan must tell you in writing how to appeal. After you file an appeal, the plan will review its decision. Then, if your plan does not decide in your favor, an independent organization that works for Medicare, not the plan, reviews the appeal.

If you are in a Medicare managed care plan, or a Private Fee-for-Service plan, call the plan and ask...	**Plan:**	**Plan:**	**Plan:**
Does the plan have a patient advocate/ombudsman to help members?			
What is the plan's record with appeals and grievances (complaints)?			

Other Questions You May Wish to Ask

Write your questions here:	Plan:	Plan:	Plan:

Benefit Period—The way that Medicare measures your use of hospital and skilled nursing facility services. A benefit period starts the day you go to a hospital or skilled nursing facility. The benefit period ends when you haven't received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after 60 days, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

Coinsurance—The percent of the Medicare-approved amount that you have to pay after you pay the deductible for Part A and/or Part B. In the Original Medicare Plan, the coinsurance payment is a percentage of the approved amount for the service (like 20%).

Copayment—In some Medicare health plans, the amount you pay for each medical service, like a doctor visit. A copayment is usually a set amount you pay for a service. For example, this could be $5.00 or $10.00 for a doctor visit. Copayments may also be used for hospital outpatient services in the Original Medicare Plan later this year.

Deductible (Medicare)—The amount you must pay for health care before Medicare begins to pay, either each benefit period for Part A, or each year for Part B. These amounts can change every year.

Medicare Managed Care Plan—These are health care choices in some areas of the country. In most plans, you can only go to doctors, specialists, or hospitals on the plan's list. Plans must cover all Medicare Part A and Part B health care. Some plans cover extras, like prescription drugs. Your costs may be lower than in the Original Medicare Plan.

Emergency Care—Care given for a medical emergency when you believe that your health is in serious danger—when every second counts.

Medicare Medical Savings Account Plan (MSA)—A Medicare health plan option made up of two parts. One part is a Medicare MSA Health Insurance Policy with a high deductible. The other part is a special savings account where Medicare deposits money to help you pay your medical bills.

Medigap—A Medicare supplemental health insurance policy sold by private insurance companies to fill "gaps" in Original Medicare Plan coverage. Except in Minnesota, Massachusetts, and Wisconsin, there are 10 standardized policies labeled Plan A through Plan J. Medigap policies only work with the Original Medicare Plan.

Original Medicare Plan—A pay-per-visit health plan that lets you go to any doctor, hospital, or other health care provider who accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved

amount, and you pay your share (coinsurance). The Original Medicare Plan has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance).

Peer Review Organization (PRO)—Groups of practicing doctors and other health care experts. They are paid by the federal government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by: inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Private Fee-for-Service plans, and ambulatory surgical centers.

Primary Care Doctor— A doctor who is trained to give you basic care. This includes: being the first one to check on health problems; coordinating your preventive health care with other doctors, specialists, and therapists. In many Medicare managed care plans, you must see your primary care doctor before you can see any other health care provider.

Private Fee-For-Service Plan— A private insurance plan that accepts Medicare beneficiaries. You may go to any doctor or hospital you want. The insurance plan, rather than the Medicare program, decides how much you pay for the services you get. You may pay more for Medicare-covered benefits. You may have extra benefits the Original Medicare Plan does not cover.

Referral—A written OK from your primary care doctor for you to see a specialist or get certain services. In many Medicare managed care plans, you need to get a referral before you get care from anyone except your primary care doctor. If you do not get a referral first, the plan may not pay for your care.

Urgently Needed Care—Care that you get for a sudden illness or injury that needs medical care right away, but is not life threatening. Your primary care doctor generally provides urgently needed care if you are in a Medicare health plan other than the Original Medicare Plan. If you are out of your plan's service area for a short time and cannot wait until you return home, the health plan must pay for urgently needed care.

Notes

U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES

Health Care Financing Administration

7500 Security Boulevard
Baltimore, Maryland 21244–1850

Publication No. HCFA–10113
Revised July 2000

HCFA
MEDICARE • MEDICAID
Health Care Financing Administration

www.medicare.gov

The Official U.S. Government Site for Medicare Information

Established by the Health Care Financing Administration (HCFA)

HCFA's website has useful information for Medicare beneficiaries and those involved in helping them make health care decisions. The main topics are:

★ *Search and Compare Tools*

Search for information on health plans, nursing homes, Medigap policies, phone contacts, and Medicare activities in your area.

★ *Medicare Plan Choices*

Learn about Original Medicare, managed care, Private Fee-For-Service, and Medigap policies. You can also compare health plans available in your area.

★ *Nursing Homes*

How to choose a nursing home (alternatives, payment, checklist, patient rights). You can also compare nursing homes in your area.

★ *Helpful Contacts*

Phone numbers and web sites for help in answering your questions.

★ *Publications*

View, print, or order Medicare or health related publications.

★ *Fraud and Abuse*

How to recognize and prevent fraud and abuse.

★ *Health Information*

Contains important information and links to health websites to help you stay healthy.

★ *Medicare Basics*

Information on coverage, eligibility, enrollment, and help with health care costs.

HCFA
MEDICARE • MEDICAID
Health Care Financing Administration

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

Publication # HCFA-11018
June 2000

Search and Compare Tools to Find the Information You Need:

Medicare Health Plan Compare

Comparison shop for health plans by looking at costs, benefits, quality, and plan member disenrollment rates. Health plans include: Original Medicare Plan, Medicare managed care plans (HMOs), and Private Fee-for-Service plans.

Medigap Compare

Helps you find supplemental insurance policies available in your area to cover expenses not paid by Medicare.

Nursing Home Compare

Helps you compare nursing homes in your area by looking at nursing home characteristics, resident characteristics, state inspection results, and nursing staff information.

Helpful Contacts

Allows you to find phone numbers and web sites for help in answering your questions.

Local Medicare Events

Gives you details about events on Medicare-related topics in your area, and information about how you can attend.

Seniors are Surfing the Net

Some interesting facts:

More and more, people with Medicare and those who will soon be eligible for Medicare use the Internet. The following research shows that Internet use is growing among people age 50 and older:

Internet access among people with Medicare has increased dramatically from 1997 to 1999. Findings from the HCFA-sponsored Medicare Current Beneficiary Survey indicate that the percentage of Medicare beneficiaries reporting access to the Internet climbed from 6.8% in 1997 to 21.3% in 1999.

According to Jupiter Communications, older adults (50+) spend more hours online each week than any other age group. Older adults spend an average of 8.3 hours online each week, with college students spending 7.8 hours, adults aged 19-50 spending 7.7 hours and teens 13-18 spending 5.9 hours online.

Senior citizens are the fastest growing sector of the online audience, exploding from a meager 600,000 in 1995 to an estimated 13 million in 1998 according to SeniorNet. An eMarketer recently released eRetail Report supports this trend: in 1999, almost 10 million seniors, or 17% of all Americans aged 55+, were active internet users.

Eighty-three percent of surveyed senior surfers like the ability to get news or investigate a topic online. Of those, 49% went online to find medical information, according to Interactive PR and Marketing News (Sept. 1999).

Medicare & You
The knowledge to make good decisions

National Medicare Education Program (NMEP)
Regional Office Contacts
Updated June 2000

REGION	Partnering Lead	NMEP Lead	Alternate
Region I - Boston Maine, Connecticut, Massachusetts, New Hampshire, Rhode Island, Vermont	Craig Schneider	Craig Schneider (617) 565-1189 (617) 565-1234 (fax)	Marva Nathan 9617) 565-3856
Region II - New York New York, New Jersey, Puerto Rico, Virgin Islands	Robin Thomas-Naarden (212) 264-3660	Reginald Slaten (212) 264-1122 (212) 264-2665 (fax)	Robin Thomas-Naarden (212) 264-3660
Region III - Philadelphia Delaware, Pennsylvania, Maryland, District of Columbia, Virginia, West Virginia	Patricia Antrobus	Peter Goodman (215) 861-4213 (215) 861-4176 (fax)	Patricia Antrobus (215) 861-4325
Region IV - Atlanta Alabama, North Carolina, South Carolina, Georgia, Florida, Kentucky, Mississippi, Tennessee	Michael Henderson (404) 562-7231	Teresa Wilson (404) 562-7235 (404) 562-7203 (fax)	Mike Pierson (404) 562-7203
Region V - Chicago Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin	Rita Wilson	Druecilla Brown (312)353-9845 (312) 886-5705 (fax)	Rita Wilson (312) 886-5213
Region VI - Dallas Arkansas, Louisiana, New Mexico, Oklahoma, Texas	Annette Robles (214) 767-6448	Susan McLaughlin (214) 767-6487 (214) 767-0323 (fax)	Magda Flores 9214) 767-3018
Region VII - Kansas City Iowa, Kansas, Missouri, Nebraska	Denise Buenning	Darcy Jakopchek (816) 426-6317 ext. 3407 (816) 426-3760 (fax)	Denise Buenning (816) 426-6317 ext. 3419
Region VIII - Denver Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming	Dennis DelPizzo (303) 844-1569	Diane Kocher (303) 844-7057 (303) 844-3753 (fax)	Lisa Gaglia-Blyle (303) 844-7168
Region IX - San Francisco American Samoa, Arizona, California, Guam, Hawaii, Nevada	Jane Riney (415) 744-3653	Henry Tyson (415) 744-3434 (415) 744-3761 (fax)	Neil Merino (415) 744-3652
Region X - Seattle Alaska, Idaho, Oregon, Washington	Stefanie Novacek	Sharrion Jones (206) 615-2368 (206) 615-2363 (fax)	Stefanie Novacek 9206) 615-2406

WORKING TOGETHER — IDEAS FOR THE FUTURE

POSSIBLE HEALTH CARE FINANCING ADMINISTRATION (HCFA) - LIBRARY PROJECTS/ACTIVITIES

ARE YOU INTERESTED IN ATTRACTING MORE SENIORS TO YOUR LIBRARY?

The Health Care Financing Administration (HCFA), the Federal agency that administers Medicare, has a consumer friendly website: www.medicare.gov. This popular site receives 1.5 million page views each month and features Nursing Home Compare, Medicare Compare, and a list of helpful Medicare publications on Medicare Supplemental insurance plans, and Medicare managed care, among others. The www.medicare.gov website provides an ideal example of the valuable Internet based health care information resources available to seniors, and it's ease of use makes it a great "first stop" for new web surfers!

HERE ARE TWO EXAMPLES OF INTERNET ACTIVITIES FOR SENIORS:

INTERGENERATIONAL MEDICARE ACTIVITIES

HCFA Regional office staff could assist librarians in organizing intergenerational Medicare activities, e.g., youth from local community programs such as 4H, could introduce grandparents and other seniors to the Internet and ultimately how to get to www.medicare.gov. If you would like to set up a program in your library, please call the HCFA Regional Office Contact for your area. The contacts are listed under the resource tab.

SENIORS HELPING SENIORS NAVIGATE THE WEB

Computer savvy seniors can help their less knowledgeable peers access the Internet and learn about their health care choices at www.medicare.gov. For assistance in establishing a program like this in your library visit Senior Net at www.seniornet.org, or call 1-800-747-6818.

HERE ARE OTHER WAYS TO REACH SENIORS WITH MEDICARE ACTIVITIES:

CREATE A SENIOR CORNER

- Libraries could designate an area with relevant Medicare, and health care resources and referral information.
- HCFA could provide publications and videos for display of Medicare and other related health care topics.

HOST A MEDICARE & YOU DAY

- HCFA Regional office staff could conduct Health and Information Fairs.
- HCFA could coordinate library programs and provide on site Medicare counseling by local staff of the American Association of Retired Persons or the State Health Insurance Advisory Program.

HIGHLIGHT MEDICARE IN LIBRARY NEWSLETTERS

If you are looking for informative senior related copy for your library newsletter, HCFA routinely publishes articles on Diabetes, Flu, and Mammography, as well as other topics. A Regional Office Medicare team could submit copy to the library for inclusion in the library newsletter or other publications.

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SPONSOR A MEDICARE MONDAY

- HCFA staff could provide Medicare information to libraries so that the library can sponsor a "Medicare Monday" each month to keep patrons apprised of health care options and information available to them.
- HCFA might videotape a personal opening message and send supplementary handouts for library staff use.

HOST LIBRARY ELDER PROGRAMS

- HCFA Regional staff could conduct Elder Programs in the library, e.g. Medicare 101, Medicare & You, Fraud and Abuse, Medicare + Choice.
- Fact sheets could be provided on a number of topics, e.g. Who is HCFA, What is Medicare, Enrollment, Supplemental insurance, etc., that patrons could take home with them.

Top 20 Medicare/Medicaid Questions and Answers

The following 20 questions and answers are the most frequently asked questions by callers to the Medicare + Choice toll free line for the time period from May 1, through May 31, 2000. These questions and answers are updated monthly on www.medicare.gov.

1. How can I get a Replacement Medicare card?

You will need to call the Social Security Administration or contact your local Social Security Office to get a replacement Medicare card. Their phone numbers can be found in the Helpful Contacts section of the medicare.gov website, or by calling 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired). Make sure you have your Medicare number ready when you call. You should receive your new card in about four weeks.

2. How can I find out if I have Medicare coverage?

You must call the Social Security Administration at 1-800-772-1213 or contact your local Social Security Office to verify your Medicare Part A and Part B coverage. This information can also be found on your red, white, and blue Medicare card.

3. I can't afford my Medicare premiums. What can I do?

If your income is limited, your State may help pay your Medicare costs such as your premiums and deductibles. Check the Helpful Contacts section of the medicare.gov website, or by calling 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) for the phone number of your State Medical Assistance Program. They can help you determine if you are qualified.

If you have Medicare Part A, your income is limited, and your financial resources such as bank accounts, stocks, and bonds are not more than $4,000 for an individual, or $6000 for a couple, you may qualify for assistance as a Qualified Medicare Beneficiary or Specified Low Income Medicare Beneficiary.

The Qualified Medicare Beneficiary Program (also known as QMB) pays the Medicare monthly Part B premium, deductibles and coinsurance. In most states, the 2000 monthly income limits are $716 for an individual and $958 for a couple.

The Specified Low Income Medicare Beneficiary Program (also known as SLMB) helps pay the Medicare monthly Part B premium for qualified Medicare beneficiaries. In most states, the 2000 Monthly Income Limits are $855 for an individual and $1145 for a couple.

4. Will I automatically be enrolled in Medicare when I turn 65?

If you are receiving Social Security or Railroad Retirement or disability benefits, you will be automatically enrolled in Medicare Part A and Part B. About 3 months prior to your 65th birthday or 24th month of disability, you will be sent an Initial Enrollment Package that will contain information about Medicare, a questionnaire and your red, white and blue Medicare card. If you want both Medicare Part A (hospital insurance) and Part B (medical insurance), you should sign your Medicare card and keep it in your wallet. If you don't want Part B coverage, you must put and X in the refusal box on the back of the Medicare card form; sign the form and return it with the card to Social Security at the address shown. You will then be sent a new Medicare card showing that you only have Part A.

5. How, when and where do I sign up for Medicare when I turn 65 if I am not yet receiving Social Security benefits?

Some people are not automatically enrolled in Medicare. You need to file an application if you are:

- eligible for Social Security or Railroad Retirement benefits but have not yet signed up for them;
- have permanent kidney failure treated with dialysis or a transplant; or
- are not eligible for Premium Free Part A; or
- are a government employee who is not eligible for Social Security or Railroad Retirement benefits.

You can call the Social Security Administration to set up an appointment or go to your local Social Security Office. The phone number for the Social Security office in your area can be found in the Helpful Contacts section of this site. Social Security will take your application, determine if you are eligible for Medicare and send you a Medicare card.

6. Who submits my bills to Medicare? How much do I have to pay?

If you are in Original Medicare, your doctor or other health care provider will file your claim with Medicare. You'll receive a statement showing how much you'll need to pay. If you do not receive a Medicare statement (Medicare Summary Notice or Explanation of Medicare Benefits), you'll need to contact your local carrier to have them send you a copy. Check the Helpful Contacts section of the medicare.gov website, or by calling 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) for the phone number of your carrier. If you have supplemental insurance or Medigap, they may pay part of your costs. Check with your supplemental insurance company to find out what they will pay.

7. What is Medicare?

Medicare is a Federal health insurance program for people 65 years or older, certain people with disabilities, and people with permanent kidney failure treated with dialysis or a transplant. Medicare has two parts - Part A which is hospital insurance, and Part B which is medical insurance.

I receive Social Security Disability checks. Am I eligible for Medicare?

ou are eligible for Medicare Part A (hospital insurance) if you are under 65 and have been getting ocial Security or Railroad Retirement Disability checks for 24 months. You may also enroll in Part (medical insurance) for a month premium of $45.50.

What is Medicare + Choice?

Medicare + Choice is a term used to describe the various health plan options available to Medicare eneficiaries.

0. How can I leave a Medicare Health Plan?

ou can leave a plan in one of 3 ways. You can:
call the plan you wish to leave and ask for a disenrollment form; or
call 1-800-MEDICARE (1-800-633-4227) to request that your disenrollment be processed over the phone; or
call the Social Security Administration or visit your Social Security Office to file your disenrollment request. The phone number for the Social Security office in your area can be found in the Helpful Contacts section of the medicare.gov website, or by calling 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired).

n most cases, you are disenrolled the month after your request is made as long as your request was iled before the 10th day of the month. If your request was made after the 10th of the month, you vill be disenrolled the first day of the second calendar month after your request was made. You do ıot need to fill out a disenrollment form if you decide to join another managed care plan. You will e automatically disenrolled from your old plan when your new plan enrollment becomes effective.

1. What medical supplies and equipment does Medicare Part B cover?

Medicare Part B helps pay for durable medical equipment such as oxygen equipment, wheelchairs, and other medically necessary equipment that your doctor prescribes to use in your home. Other tems covered by Medicare include:
- arm, leg, back and neck braces
- medical supplies such as ostomy bags, surgical dressings, splints and casts
- breast prostheses following a mastectomy
- one pair of eyeglasses with an intraocular lens after cataract surgery

Medicare pays for different kinds of durable medical equipment in different ways. Some equipment must be rented, other equipment must be purchased. Your Durable Medical Equipment Regional Carrier can provide more specific information. Check the Helpful Contacts section of the medicare.gov website, or by calling 1-800-MEDICARE (1-800-633-4227 TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) for the phone number for your Durable Medical Equipment Regional Carrier.

12. Does Medicare pay for Prescription Drugs?

Generally, Original Medicare does not cover prescription drugs. However, Medicare does cover some drugs in certain cases such as immunosuppressive drugs (for transplant patients) and oral anti-cancer drugs. You should call your Durable Medical Equipment Regional Carrier for more information. Check the Helpful Contacts section of the medicare.gov website, or by calling 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) for the phone number.

There are some Medicare Health Plans that cover prescription drugs. You can also check into getting a Medigap or supplemental insurance policy for prescription drug coverage. Medicaid may also help pay for prescription drugs for people who are eligible.

13. I didn't enroll in Medicare Part B when I turned 65 because I was still working. Can I enroll now?

You qualify to enroll in Medicare during a Special Enrollment Period if you delayed enrolling in Part B because you were working and had group health insurance through your employer or your spouse's employer. If you sign up during the Special Enrollment Period, you do not have to pay the Part B premium surcharge. Signing up for Medicare Part B will begin your 6 month open enrollment period for buying a Medigap policy. You can enroll in Part B:

- any month in which you are still covered under your current enrollment; or
- the 8-month period beginning with either the date your employment ends or the date your group health plan ends, whichever comes first.

You should contact the Social Security Administration to file an application. The phone number for the Social Security office in your area can be found in the Helpful Contacts section of this site.

14. How do I apply for Medicaid?

You will need to contact your local Medical Assistance Office to file an application for Medicaid. They will determine if you qualify for help in paying your medical and hospital bills. They may also help pay your Medicare premiums, deductibles, and co-insurance. Check the Helpful Contacts section of the medicare.gov website, or by calling 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) for the phone number of your Medicaid office.

15. What is a Medigap policy?

Supplemental insurance policies are sometimes called Medigap plans. Medigap plans are private health insurance policies that cover some of the costs the Original Medicare Plan does not cover. Some Medigap policies will cover services not covered by Medicare such as prescription drugs. Medigap has 10 standard plans called Plan "A" through Plan "J". Each plan has a different set of benefits. The states of Minnesota, Wisconsin and Massachusetts have choices other than Plan "A"

hrough Plan "J". Your State Insurance Department can answer questions about the Medigap policies old in your area. Check the Helpful Contacts section of the medicare.gov website, or by calling -800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech mpaired) for the phone number of your State Insurance Department.

16. What diabetic supplies does Original Medicare cover?

Medicare covers the same supplies for both insulin and non-insulin dependent diabetics. They nclude:

- Glucose testing monitor;
- Blood glucose test strips;
- Lancets;
- Spring powered devices for lancets
- Glucose control solutions

Some frequency limitations may apply. Medicare does not cover insulin and syringes. Contact your Durable Medical Equipment Regional Carrier for more information. Check the Helpful Contacts ection of the medicare.gov website, or by calling 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) for the phone number.

17. What types of services are covered under Medicare Part B?

Medicare Part B helps pay for doctors' services, outpatient hospital care, blood, medical equipment and some home health services. It also pays for other medical services such as lab tests and physical and occupational therapy. Some preventive services such as mammograms and flu shots are also covered.

Medicare Part B does NOT cover routine physical exams; eye glasses; custodial care; dental care; dentures; routine foot care; hearing aids; orthopedic shoes; or cosmetic surgery. It also does not cover most prescription drugs or health care you get while traveling outside the United States (except under limited circumstances).

18. Does Medicare pay for dental services?

Medicare does not cover routine dental care or most dental procedures such as cleanings, fillings or tooth extractions or dentures. There are rare cases in which Medicare Part B will pay for certain dental services. In addition, there are some situations in which Medicare Part A will pay for certain dental services delivered on an inpatient basis. You should contact your local Carrier for more information. Check the Helpful Contacts section of the medicare.gov website, or by calling 1-800-MEDICARE (1-800-633-4227 TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) for

the phone number.

19. Who is eligible for Medicare Part A (Hospital Insurance)?

If you have worked at least 10 years in Medicare covered employment you will qualify for premium free Medicare Part A (Hospital Insurance). To qualify, you must be:

- 65 or older; or
- Disabled and receiving disability benefits from Social Security or the Railroad Retirement Board for 24 months; or
- Have permanent kidney failure treated with dialysis or a transplant

You should contact the Social Security Administration to file an application. Check the Helpful Contacts section of the medicare.gov website, or by calling 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) for the phone number of the Social Security Office in your area.

20. How do Medicare managed care plans work?

Medicare managed care plans are another way for you to receive Medicare benefits. All plans must provide all of the services that you would receive under Original Medicare with some added benefits.

You usually must use the doctors, hospitals and providers in the plan's network. You may have to pay a monthly premium to your health plan. However, you would not need a supplemental Medigap policy if you join a managed care plan.

Use one of the small ads below to place in printed materials (e.g., newspapers, newsletters).

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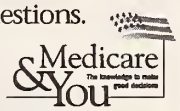

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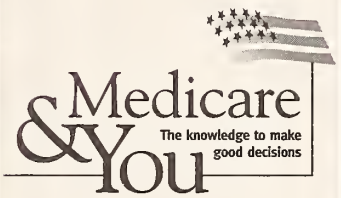

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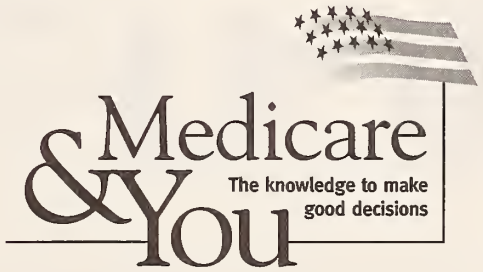

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Request Form for Medicare Health Promotion & Prevention Information

TITLE	ORDER #	QUANTITY
FAX YOUR ORDER TO 410-786-1905 FOR THE FOLLOWING PUBLICATIONS:		
Dialysis - Provides a hemodialysis patient information on two important measures to help monitor the adequacy of dialysis treatment. **HCFA - 10924**	Eng - 004645 Sp - 004515	
Get the Flu Shot, Not the Flu - Explains why the flu shot is important, and also promotes the pneumococcal shot. **HCFA - 10976 Sp/ 10977 Eng/10983 Viet/ 10979 Kor/ 10980 Chin**	Eng - 004406 Sp - 004405 Chin - 004409 Kor- 004408 Viet -004995	
Guide to Choosing A Nursing Home - Provides information about making a nursing home selection. **HCFA - 02174 Eng/ 10972 Sp**	Eng - 004380 Sp - 004392	
Medicare Coverage of Kidney Dialysis & Kidney Transplantation - Provides information on eligibility and coverage of kidney dialysis and transplantation services. **HCFA - 10128 Eng/ 10956 Sp**	Eng - 004308 Sp - 004389 Audio /Eng- 95162 Sp - 95163 Braille/Eng - 10988	
Medicare Coverage for Second Surgical Opinion - Explains when and why a second opinion may be necessary. **HCFA - 02173**	N/A Available 2/00	
Medicare Preventive Services...To Help Keep You Healthy Provides descriptions of preventive services covered by Medicare, with handy tear-out reminder cards. **HCFA - 10110**	Eng - 005121	
Medicare Savings for Qualified Beneficiaries - Explains how to get help with paying Medicare out-of- pocket expenses for some low income beneficiaries. **HCFA - 02184 Eng/ 10954 Sp**	Eng - 004309 Sp - 004393	
Sometimes Abuse in nursing homes is not so obvious - Gives helpful information for identifying abuse in a nursing home setting.	Eng - Leaflet	
CALL THE TELEPHONE NUMBERS LISTED FOR THE FOLLOWING PUBLICATIONS:		
Colorectal Cancer: Let's Break the Silence - Emphasizes the need for colorectal cancer screening tests for early detection and prevention of the disease. Availability: National Cancer Institute (1-800-4-CANCER), Centers for Disease Control and Prevention (1-888-842-6355)		
Control Your Diabetes for Life - Gives a brief summary of medical supplies covered by Medicare. Availability: National Diabetes Education Program (1-800-438-5383)	NDEP - 19	
Mammograms Not Just Once, But A Lifetime - Provides information for why and how to obtain a mammogram. Availability: National Cancer Institute (1-800-4-CANCER)	Eng - NIH 98-3418V	
Pap Tests: A Healthy Habit for Life - Gives information on why, how and who should have a Pap test. Availability: National Cancer Institute (1-800-4-CANCER)	Eng - NIH-98-3213V/H	
Other -		

SHIPPING ADDRESS

Name of Organization:_____

Contact Person:_____Phone Number_____

Address:_____

City:_____State_____Zip Code_____

Fax or call the telephone numbers shown. Thank you.

Medicare Educational Materials Request Form

Title	Pub #	Quantity
Choosing a Doctor- A guide to help Medicare beneficiaries choose a doctor for quality care.	**10180**	**Available 8/00**
Choosing a Doctor- Spanish- A guide to help Medicare beneficiaries choose a doctor for quality care.	**10903**	**Available 9/00**
Choosing a Doctor - Braille - A guide to help Medicare beneficiaries choose a doctor for quality care.	**10908**	**Available 9/00**
Choosing a Hospital - A guide to help Medicare beneficiaries choose a hospital for quality care.	**10181**	**Available 8/00**
Choosing a Hospital- Spanish- A guide to help Medicare beneficiaries choose a hospital for quality care.	**10905**	**Available 9/00**
Choosing a Hospital - Braille - A guide to help Medicare beneficiaries choose a hospital for quality care.	**10909**	**Available 9/00**
Choosing Treatments- A guide to help Medicare beneficiaries make treatment choices for quality care.	**10182**	**Available 8/00**
Choosing Treatments- Spanish - A guide to help Medicare beneficiaries make treatment choices for quality care.	**10904**	**Available 9/00**
Choosing Treatments - Braille - A guide to help Medicare beneficiaries make treatment choices for quality care.	**10910**	**Available 9/00**
Do You Need Help to Pay Health Care Costs? - English/Spanish - Help for people with low income (Medicaid)	**10118**	
Does Your Doctor or Supplier Accept Assignment? - An explanation with examples of how Assignment can save you money in the Original Medicare Plan.	**10134**	
Does Your Doctor or Supplier Accept Assignment? - Spanish An explanation with examples of how Assignment can save you money in the Original Medicare Plan.	**02152**	**Available 8/00**
Does Your Doctor or Supplier Accept Assignment? - Braille An explanation with examples of how Assignment can save you money in the Original Medicare Plan.	**10170**	
Does Your Doctor or Supplier Accept Assignment? - English Audio-tape An explanation with examples of how Assignment can save you money in the Original Medicare Plan.	**10161**	
Does Your Doctor or Supplier Accept Assignment? - Spanish Audio-tape An explanation with examples of how Assignment can save you money in the Original Medicare Plan.	**10908**	
Getting a Second Opinion Before Surgery- Information about Medicare coverage of second surgical opinions.	**02173**	**Available 8/00**
Getting a Second Opinion Before Surgery- Spanish- Information about Medicare coverage of second surgical opinions	**10902**	**Available 8/00**
Guide to Choosing a Nursing Home - English - Detailed information about how to choose a nursing home	**02174**	
Guide to Choosing a Nursing Home - Spanish - Detailed information about how to choose a nursing home	**10972**	
Guide to Choosing a Nursing Home - Braille - Detailed information about how to choose a nursing home	**10945**	
Guide to Choosing a Nursing Home - English Audio-tape - Detailed information about how to choose a nursing home	**95155**	
Guide to Choosing a Nursing Home - Spanish Audio-tape - Detailed information about how to choose a nursing home	**10165**	
2000 Guide to Health Insurance for People with Medicare - English - Comprehensive guide to Medicare Supplemental Health (Medigap) Insurance	**02110**	

2000 Guide to Health Insurance for People with Medicare - Spanish - Comprehensive guide to Medicare Supplemental Health (Medigap) Insurance	**10964**	**Available 8/00**
2000 Guide to Health Insurance for People with Medicare - Large Print in English - Comprehensive guide to Medicare Supplemental Health (Medigap) Insurance	**02143**	
2000 Guide to Health Insurance for People with Medicare - Braille - Comprehensive guide to Medicare Supplemental Health (Medigap) Insurance	**10991**	
2000 Guide to Health Insurance for People with Medicare - Audio Tape in English - Comprehensive guide to Medicare Supplemental Health (Medigap) Insurance	**95164**	
2000 Guide to Health Insurance for People with Medicare - Audio Tape in Spanish - Comprehensive guide to Medicare Supplemental Health (Medigap) Insurance	**97171**	**Available 8/00**
Dialysis - English - Information about adequate hemodialysis	**10924**	
Dialysis - Spanish - Information about adequate hemodialysis	**10933**	
Medicare & You 2000 - English - National version of Medicare's beneficiary handbook	**10050**	
Medicare & You 2000 - Spanish - National version of Medicare's beneficiary handbook	**10950**	
Medicare & You 2000 - Large Print in English - National version of Medicare's beneficiary handbook	**02139**	
Medicare & You 2000 - Large Print in Spanish - National version of Medicare's beneficiary handbook	**02140**	
Medicare & You 2000 - Braille - National version of Medicare's beneficiary handbook	**10990**	
Medicare & You 2000 - Audio Tape in English - National version of Medicare's beneficiary handbook	**95167**	
Medicare & You 2000 - Audio Tape in Spanish - National version of Medicare's beneficiary handbook	**95166**	
Medicare and Other Health Benefits: Your Guide to who pays first- An explanation of how Medicare pays with other types of insurance.	**02179**	**Available 8/00**
Medicare and Other Health Benefits: Your Guide to who pays first- Spanish- An explanation of how Medicare pays with other types of insurance.	**10975**	**Available 9/00**
Medicare Appeals and Grievances - How to file an appeal or grievance if you have a complaint.	**10119**	
Medicare Coverage of Kidney Dialysis and Transplant Services - English - Information about Medicare coverage for those with End-Stage Renal Disease (permanent kidney failure treated with dialysis or a transplant.	**10128**	**Available 9/00**
Medicare Coverage of Kidney Dialysis and Transplant Services - Spanish - Information about Medicare coverage for those with End-Stage Renal Disease (permanent kidney failure treated with dialysis or a transplant.	**10988**	**Available 9/00**
Medicare Coverage of Kidney Dialysis and Transplant Services - Braille - Information about Medicare coverage for those with End-Stage Renal Disease (permanent kidney failure treated with dialysis or a transplant.	**10988**	**Available 9/00**
Medicare Coverage of Kidney Dialysis and Transplant Services - English Audio-tape - Information about Medicare coverage for those with End-Stage Renal Disease (permanent kidney failure treated with dialysis or a transplant.	**95162**	**Available 10/00**
Medicare Coverage of Kidney Dialysis and Transplant Services - Spanish Audio-tape - Information about Medicare coverage for those with End-Stage Renal Disease (permanent kidney failure treated with dialysis or a transplant.	**95163**	**Available 10/00**
Medicare Coverage of Kidney Dialysis and Transplant Services - English Large Print - Information about Medicare coverage for those with End-Stage Renal Disease (permanent kidney failure treated with dialysis or a transplant.	**10128-LE**	**Available 10/00**
Medicare Coverage of Kidney Dialysis and Transplant Services - Spanish Large Print - Information about Medicare coverage for those with End-Stage Renal Disease (permanent kidney failure treated with dialysis or a transplant.	**10128-LS**	**Available 10/00**

Medicare Fraud and Abuse - How to identify fraud and abuse, and how to protect yourself and the Medicare program.	**10111**	**Available 8/00**
Medicare Fraud and Abuse - Spanish How to identify fraud and abuse, and how to protect yourself and the Medicare program.	**10907**	**Available 9/00**
Medicare Health Plan Nonrenewal Fact Sheet- Information on health plan nonrenewal and contact numbers for State Health Insurance Counseling Programs by state.	**10173**	
Medicare Home Health - English - An explanation of Medicare's home health care coverage.	**10969**	
Medicare Home Health - Spanish - An explanation of Medicare's home health care coverage	**10971**	
Medicare Home Health - Braille - An explanation of Medicare's home health care coverage	**10969-B**	
Medicare Home Health - English Audio-tape - An explanation of Medicare's home health care coverage	**95152**	
Medicare Home Health - Spanish Audio-tape - An explanation of Medicare's home health care coverage	**95153**	
Medicare Hospice Benefits - English - An explanation of Medicare's hospice care coverage.	**02154**	
Medicare Hospice Benefits - Spanish - An explanation of Medicare's hospice care coverage.	**10951**	
Medicare Hospice Benefits - Braille - An explanation of Medicare's hospice care coverage.	**10986**	
Medicare Hospice Benefits - English Audiotape - An explanation of Medicare's hospice care coverage.	**95156**	
Medicare Hospice Benefits - Spanish Audio-tape - An explanation of Medicare's hospice care coverage.	**10166**	
Medicare Medical Saving Account Plan Brochure - Detailed information about Medicare Medical Savings Accounts.	**02137**	
Medicare Medical Savings Account Plan Offers You a New Option (Fact Sheet)* - A brief introduction to the new Medicare Medical Savings Account Plan option.	**10107**	
Medicare Mental Health Benefits- An explanation of Medicare's coverage of mental health care.	**10184**	**Available 9/00**
Medicare Mental Health Benefits- Spanish- An explanation of Medicare's coverage of mental health care.	**10906**	**Available 10/00**
Your Guide to the Medicare Outpatient Prospective Payment System- Explanation of Medicare's new system for paying for outpatient services.	**02118**	**Available 8/00**
Your Guide to the Medicare Outpatient Prospective Payment System- Spanish- Explanation of Medicare's new system for paying for outpatient services.	**10901**	**Available 9/00**
Medicare Patient Rights - Lists your rights as a Medicare beneficiary.	**10112**	
Medicare Preventive Services...To Help Keep You Healthy* - Descriptions of preventive services covered by Medicare, with handy tear-out reminder cards.	**10110**	
Medicare Preventive Services...To Help Keep You Healthy - Spanish Descriptions of preventive services covered by Medicare, with handy tear-out reminder cards.	**10179**	**Available 8/00**
Medicare Private Fee-for-Service Plan Brochure - English - Detailed information about Medicare Private Fee-for-Service Plans.	**10173**	
Medicare Private Fee-for-Service Plan Brochure - Spanish - Detailed information about Medicare Private Fee-for-Service Plans.	**10105**	
Medicare Savings for Qualified Beneficiaries - English - Information on help paying health care costs	**02184**	
Medicare Savings for Qualified Beneficiaries - Spanish - Information on help paying health care costs	**10954**	
Medicare Savings for Qualified Beneficiaries - Braille - Information on help paying health care costs	**10969**	
Medicare Coverage of Skilled Nursing Facility Care- Information on Medicare coverage of care in a skilled nursing facility.	**10153**	**Available 9/00**

Medicare Coverage of Skilled Nursing Facility Care- Spanish- Information on Medicare coverage of care in a skilled nursing facility.	**10163**	**Available 10/00**
Medigap Policies and Protections - Information about Medicare Supplemental Health Insurance (Medigap/Medicare SELECT) Policies and Protections.	**10139**	**Available 8/00**
Medigap Policies and Protections - Spanish Information about Medicare Supplemental Health Insurance (Medigap/Medicare SELECT) Policies and Protections.	**10900**	**Available 9/00**
New Health Insurance Now Available for Infants, Children and Teens - Information on the Children's Health Insurance Program, a State program to help provide free health coverage for children in low-income families.	**10135**	
Nursing Homes - Basic Information on how to choose a nursing home.	**10121**	
Private Contracts with Doctors and Other Practitioners Who Have Decided Not to Provide Services Through the Medicare Program (Fact Sheet) - A brief explanation of Private Contracts.	**10109**	
Understanding Your Medicare Choices* - Brief description of Medicare health plan options.	**10120**	
Understanding Your Medicare Choices - Spanish Brief description of Medicare health plan options	**10185**	**Available 8/00**
Worksheet for Comparing Medicare Health Plans - Worksheet that can be used to help you compare Medicare health plans.	**10113**	**Available 8/00**
Medicare.gov - Overview of HCFA's consumer based Internet site.	**10108**	
Your Medicare Benefits* - An explanation of Part A and Part B benefits.	**10116**	

If language is not stated, publication is in English.

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Contact Person:_____**Phone Number:**_____
Address (No P.O. Boxes):_____
City:_____**State:**_____**Zip Code:**_____

Special Shipping Instructions:_____

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Revised 7/25/2000

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